ARIZONA MEDICINE

Journal of ARIZONA MEDICAL ASSOCIATION

Vol. 14, No. 11 — November, 1957

Table of Contents

Published monthly by the Arizona Medical Association. Business office at 321 Mayer Heard Building, Phoenix, Arizona. Subscription $5.00 a year, single copy 50c. Entered as second class matter March 1, 1921, at Postoffice at Phoenix, Arizona, Act of March 3, 1879.

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ARIZONA MEDICINE
Journal of Arizona Medical Association

VOL. 14, NO. 11 NOVEMBER, 1957

Original Articles

LAS FILOSOFIAS CONTEMPORANEAS SOBRE EL TRATAMIENTO DEL TRAUMA CRANEO-CEREBRAL

By Juan E. Fonseca, M.D.

Tucson, Arizona

Con el advenimiento del automóvil, la protección ósea del cerebro parece ser impotente ante el enorme impacto a que se somete la cabeza en los choques, vuelcos y frenazos que ocurren con creciente frecuencia de acuerdo con la creciente accesibilidad de este vehículo, y, en especial, con el aumento inaudito del caballaje y velocidad que son capaces de desarrollar estos modernos carros. En el año de 1956 murieron 40,000 personas en los Estados Unidos como consecuencias de accidentes automovilísticos, y fueron lesionadas millón y medio.

Son los traumatismos cerebrales de tipo "cerrado" los que predominan en el ejercicio de la neurocirugía countemporánea, las heridas "abiertas" o penetrantes constituyendo una pequeña minoría. Es el desgarre o contusión de la masa encefálica, con su correspondiente hemorragia intracerebral, subaracnoidea y subdural, y la llamada conmoción cerebral, ambos debidos al movimiento de la tal masa dentro de la bóveda craneana cuya rigidez impide el desempeño de las leyes físicas de la inercia, los que constituyen las principales entidades anatomo-patológicas que resultan de los traumatismos corrientes.

Las fracturas del craneo, muy conocidas del elemento laico y por los abogados, en realidad no tienen la importancia clini-quirúrgica de las lesiones traumáticas del cerebro propio.

Para epilogar estos comentario de prefacio, permítaseme anotar que son el juicioso manejo clínico del médico, y el asiduo y diligente cuidado de la enfermera de cabecera, los factores que salvan la vida con más frecuencia que las operaciones dramáticas de decompresión.

Cataloguemos someramente los traumatismos aque nos referimos: En primer lugar la *contusión* cerebral incluye aquellas lesiones relativamente focales representadas por cambios anatómicos con ligera destrucción histológica y algun derrame sanguíneo, y produciendo, en el plano

(English translation on Page 651)

clínico, leves signos neurológicos de caracter focal, no necesariamente acompañados por pérdida de conocimiento.

En segundo término nos referiremos a la *conmoción* cerebral, o sea la pérdida temporal del conocimiento, después de un trauma, sin alteraciones anatómicas en la masa encefálica; constituye, pués este fenómeno, una alteración fisiológica y funcional cuya sede y exacto mecanismo se desconocen.

La *rasgadura* del cerebro ocurre en los traumas mayores, aún cuando no hay penetración de la bóveda ósea, como resultado de una ruptura de la corteza cerebral que ocurre espontáneamente por la súbita aceleración y deceleración inherentes al golpe, o también por rebote contra el borde del ala mayor del esfenoide. La rasgadura va generalmente acompañada de hemorragia intracerebral e intermeníngea.

Las *hemorragias* traumáticas son generalmente consecuencia de una contusión o rasgadura, pero a veces ocurren en formas más pura, limitándose el interior de la masa encefálica, incluyendo el tallo cerebral; o el derrame puede penetrar el sistema ventricular, con pronóstico gravisimo; y, por fin, puede extravasarse en los planos intermeníngeos, como el subpial, el subaracnoideo y el subdural.

La acumulación sanguínea *subdural* merece un nicho especial en nuestra categorización, ya que puede también resultar de un trauma relativamente leve, en que se efectúa la ruptura de una de las venas que cruzan con poco soporte entre la corteza y el seno venoso longitudinal superior, en cuya situación se lleva a cabo un proceso de encapsulamiento del coágulo que gradualmente se desintegra y hemoliza en un líquido hipertónico hiperproteínico que, por osmosis, tiende a aumentar de volúmen mientras que la cápsula se engruesa, produciendo así, a la postre, fenómenos de presión cerebral progresivos, con características focales, que exigen evacuación quirúrgica.

El *higroma* subdural comprime como el hematoma, y es una creciente acumulación de líquido céfalo-raquídeo que se derrama por un pequeño desgarre de la aracnoide.

Los hematomas *epidurales*, más raros, implican, por lo general, una fractura de cráneo que interesa uno de los troncos arteriales de la circulación dural, que, una vez rotos, disecan, por la presión hemorrágica, la dura de la tabla interna de la bóveda craneana hasta producir, con suma rapidez, un hematoma compresor del cerebro que quede producir la muerte en pocas horas.

Las *fracturas* de cráneo son, por lo general, lineales cuando el golpe es difuso. Las que son deprimidas son, en su mayor parte, compuestas, y resultan de la penetración o impacto momentáneo de un cuerpo comparativamente agudo.

El *edema* del tejido del neuro-eje inspira respeto al más optimista de los estudiantes del sistema nervioso; y es, como es natural, una secuela del traumatismo, más bien que un resultado directo del golpe.

Las heridas *penetrantes* del cerebro implican fractura compuesta del cráneo, con entrada transdural, y son producidas, por lo general, por proyectil, metralla, u objetos agudos.

En cuanto a las manifestaciones clínicas de las lesiones arriba mendionadas, deben subdividirse los cuadros en operables y no-operables.

Son *operables*, por lo usual, aquellos traumatismos "abiertos" en que haya que llevar a cabo una debridación de cuerpos extraños, fragmentos óseos o tejidos necrotizados, antes de suturar los planos anatómicos de dura, gálea y piel. También son operables aquellos cuadros en que existen señales de que la presión intracranial aumenta gradualmente y las funciones vitales del enfermo deterioran.

En cuanto a los *no-operables*, debe percatarse a groso modo, el facultativo en su primer contacto con el lesionado, del estado de las funciones vitales. Me refiero, naturalmente, al grado en que responde el enfermo a los estímulos dolorosos, como la presión sobre el nervio supraorbitario, los pellizcos, pinchazos, etc. Huelga men-

cionar, desde luego, que todo tipo de observación atañe también a los casos considerados operables. Establecen, pues, estas anotaciones sobre el enfermo, una base de comparación para estimar cambios posteriores en el nivel de conciencia y profundidad del coma. Debe notarse tambien si el enfermo, al responder a estímulos dolorosos, muestra una hemiplejia o si, por el contrario, mueve igualmente todas las extremidades.

En segundo lugar, debe anotarse la presión arterial y el pulso. En caso de shock, el uso de hipertensores por goteo endovenoso, como el levofed, puede que sea necesario, aunque el colapso vascular periférico es rara compicación en estos casos.

La preservación de la integridad de las vías aereas, que permita la oxigenación adecuada del cerebro, es uno de los cuidados que requieren más constante atención y que con mayor frecuencia se ignoran o menoscaban. El médico o enfermera que ignora el estridente ronquido o el burbujeo traqueal o naso-faríngeo de sangre o secreciones aspiradas, o la taquipnea y la cianosis del comatoso que se asfixia por obstrucción mecanica de las vías respiratorias, no merece ni mi respeto ni la gratitud del lesionado. Debe haber, a mano, una bomba de succión utilizando un simple cateter de hule con la apertura en el extremo. Una broncoscopía de aspiración pudiera ser necesaria. A veces el simple uso de la succión frecuente por las vías nasal y bucal es suficiente, en conjunción con un abatelengua semirígido. A veces la intubación endotraqueal o la traqueotomía, que hacemos con relativa frecuencia en los lesionados cerebrales, son responsables de muchas vidas salvadas.

Observaciones de carácter más específicamente neurológico deben hacerse, después de haber determinado si hay algun otro traumatismo, como fractura-dislocation del cuello, de la columna toraco-lumbar, de las extremidades, ruptura de vísceras abdominales, etc. Me refiero, en especial, a la reacción pupilar, a la presencia de reflejos patológicos como el Babinski, etc. A discreción del médico una *punción lumbar*, si el enfermo no está extremadamente inquieto, puede arrojar datos de interés, como la presión del líquido, la cual es fácil de medir con el manómetro de agua, y el grado de hemorragia, ambos de los cuales pueden redeterminarse posteriormente para seguir la evolución del caso.

Aunque útil para excluir fracturas deprimidas que deban operarse, o fracturas que interesen la arteria meníngea media que deban ponernos en guardia contra los estragos de la hemorragia epidural, o desviaciones de la glándula pineal calcificada, la *radiografía de cráneo* puede posponerse hasta que la condición del lesionado se estabilize o su inquietud lo haga más fácil de manejar.

Una vez encamado, el comatoso, si es del todo posible, merece la atención constante de una enfermera especial que cuide de mantener intactas las vías respiratorias, que siga el curso del pulso y de la presión, y que administre los sedantes para la inquietud evitando que el enfermo se lastime. La *inquietud*, producto de la hipoxia cerebral, constituye un reto a la paciencia e ingenuidad del médico. Usamos nosotros el fenobarbital, el paraldehido, el cloral; últimamente nos inclinamos a los derivados de la rauwulfia ye de la promazina.

Los *líquidos* no deben restringirse excepto en raros casos en que parezca que el edema juega papel importante. De otro modo de 2,000 a 3,000 mililitros deben administrarse a diario por la vía endovenosa, incluyendo 1,000 mililitros de suero salino, y el resto en suero glucosado o hidrolisados de proteina cada 24 horas. Si el enfermo no recobra el conocimiento o es capaz de ingerir sus propios líquidos, se le intuba el estomago por la via nasal con una sonda de polietileno fina, que se deja in situ indefinidamente, y se le administra por la misma, una dieta líquida de 2,000 a 3,000 mililitros con un valor calórico de 1,000 a 2,000 calorías. *La incontinencia* urinaria se controla con un cateter permanente que se cambia semanalmente.

La *fiebre* es otro problema que requiere frecuente atención, ya que la hiperpirexia de orígen cerebral puede llegar con suma rapidez a niveles elevadísimo sque son incompatibles con la vida. El tratamiento, por medios físicos, de este trastorno del centro termo-regulador del cerebro, es

el más racional, y consiste en exponer las superficies cutáneas a la atmósfera ambiente destapando al enfermo; las aplicaciones de toallas enchumbadas en alcohol o de sábanas humedecidas en agua helada, son eficaces; la aspirina, por la vía oral o rectal, es también empleada.

Aunque el 75% de los casos de coma por trauma cerebral sobreviven sin necesidad de operación, los hematomas e higromas subdurales, y los hematomas epidurales necesitan evacuación quirúrgica. Se indica la *trepanación*, repito, cuando el cuadro deteriora con el enfermo respondiendo paulatinamente menos vigorosamente a los estímulos, la presión ascendiendo, el pulso alentándose, etc. Trepanaciones bitemporales son las más corrientes, y se hallan la mayoría de los hematomas e higromas por esta vía. Siempre deben hacerse en ambos lados en el caso de los *subdurales*. Se hacen también si el lesionado se estaciona en su progreso de manera inexplicable. Se practica también la trepanación temporal cuando se sospecha hemorragia *epidural*. En estos casos la evolución de los síntomas localizantes es rápida, y hay una fractura lineal hacia la base de la fosa temporal; la pupila homolateral generalmente se dilata, y hay una hemiplejia contralateral; se palpa también una tumefacción de la región temporal homolateral en el músculo temporal, y el individuo progresa rápidamente hacia un coma profundo. Con tal cuadro, la trepanación sin demora es mandatoria: al atravesar la tabla interna se ve el hematoma; se ensancha el agujero con rongeurs rápidamente, y se aspira el coágulo hasta encontrar el orígen de la hemorragia. Enconces se aplica un clip de plata o se cauteriza la meníngea media.

La convalescencia y rehabilitación de estos enfermos es excepcionalmente satisfactoria y completa salvo cuando hay motivación de ganancia por litigio legal, o en indivíduos de avanzada edad. Recientemente se viene recomendando la ambulación precoz y la rehabilitación rápida, en contraste con el prolongado reposo de cama y limitación de actividad que, con frecuencia, da lugar a una invalidez psicosomática.

Para concluir, quiero de nuevo poner de relieve la importancia del manejo juicioso, alerta y diligente del lesionado, en los planos que enumeré, más bien que en los procesos operatorios que, por lo general, son útiles solamente en manos de aquellos facultativos que poseen experiencia especial en esas técnicas.

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CURRENT THINKING ON THE MANAGEMENT OF CRANIOCEREBRAL TRAUMA*

By Juan E. Fonseca, M.D.
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WITH the advent of the automobile, the bony protection of the brain seems inadequate against the terrific impact to which the head is apt to be subjected in a collision. The situation has become aggravated by the increasing accessibility of the automotive vehicle, as well as by the increased prevalent speed and horsepower of present day car production. In 1956 upward of 40,000 Americans lost their lives in this manner, and a total of 1½ million were injured.

It is the "closed" head injury that constitutes the great majority of the tally, "open" and "penetrating" lesions occurring less frequently. It is the laceration, or contusion, of the brain with its accompanying intracerebral, subarachnoid and subdural hemorrhage, and the so-called "concussion," which represent the leading mechanism in the closed head injury. It is partly a by-product of the violent acceleration and deceleration of the semi-fluid brain against the rigid walls of the cranial vault.

The skull fracture, per se, is an entity well known to the lay folks and to the attorney who dabbles in personal injury litigation; but as such, it has much less significance than the extent of the brain damage proper.

To close these prefatory remarks, I wish to note that the diligent, judicious and assiduous management by the attending physician, together with alert nursing care, are more responsible for saving lives than any dramatic decompressive operation.

Let us briefly catalog the various types of trauma that we are here to discuss:

In the first place, the cerebral *contusion* represents a fairly focal lesion with its corresponding focal clinical signs, incident to "bruising" of the brain, and not necessarily associated with loss of consciousness.

Cerebral *concussion* in its pure form, implies a temporary loss of consciousness attributable to a physiological derangement of brain function lacking a demonstrable anatomical counterpart.

Lacerations of the brain follow major trauma, even in closed injuries, and represent a spontaneous tear from the impact, or from striking the edge of the greater wing of the sphenoid. They produce intracerebral or subarachnoid hemorrhage.

Hemorrhages can also occur from a contusion or from a true rupture of a vessel on the surface or inside the brain, thus producing intermeningeal (subpial, subarachnoid or subdural) or pure intracerebral hemorrhage respectively. Bleeding into a ventricle carries a grave prognosis.

The well known *subdural hematoma* deserves a special niche in this outline because of its surgical implications and because it may follow a trivial injury. Although it can follow a brain laceration, it is said to be often due to a tear in bridging cortical veins which drain into the superior longitudinal sinus. This subdural accumulation of blood coagulates and develops a capsule. Through hemolysis and osmosis its volume tends to increase gradually even as the active hemorrhage had long before ceased, and the capsule organizes and thickens, holding a progressively larger volume of dark yellow fluid with a high protein content, which will produce increasing focal signs of intracranial hypertension requiring surgical evacuation.

The subdural *hygroma* evolves from an arachnoidal tear that allows unidirectional spillage of CSF from the subarachnoid to the subdural compartments, creating, again, a pressure situation calling for surgical relief much as the hematoma.

The *epidural hematoma* is rare and ordinarily follows a skull fracture across the more proximal portion of the middle meningeal artery, which it tears, producing a rapidly progressive hematoma which dissects the dura from the skull and eventuates in acute cerebral compression which can kill in a few hours.

Fractures of the skull are generally linear if the blow is diffuse. The depressed ones usually are compound and are due to the impact of a hard object with a small or sharp surface.

Edema of the brain is a common indirect result

*Presented May, '57, before the Medical Society of the United States and Mexico.

of brain injury which has always inspired respect and fear among the students of the nervous system.

Penetrating wounds of the brain naturally presuppose a compound fracture of the cranium, with transdural trespassing, and are ordinarily produced by missiles, sharp objects, etc.

Concerning the clinical manifestations of the above captioned types of head injury, these should be subdivided as operable and non-operable.

Among the *operable* or truly surgical, the open wounds head the list, and the time tested principles of debridement and closure in layers obtain when the wound is not too old or grossly infected. Also operable are those injuries where there are progressive signs of increased intracranial pressure, especially if associated with focal characteristics and deterioration of vital signs.

In the management of the *medically manageable* cases, a careful appraisal of the vital signs and neurologic status is as important as in the surgical, which they can develop into. I refer, in particular, to the degree of responsiveness to painful stimuli, such as supraorbital pressure, pinching and sticking with a pin. A record of such responsiveness serves as a basis for comparison with later observations which allows for more accurate following of the evolution of the clinical picture. In testing with painful stimuli one must watch for evidence of hemiplegia if the coma is not too deep. Pulse, BP, temperature and respiratory rate should also be recorded at frequent intervals. Although peripheral vascular collapse is rare, occasionally the use of sympathomimetic drugs by intravenous drip becomes necessary.

It is the preservation of an *adequate airway*, however, that is most often overlooked and underestimated. The surgeon or nurse must be alerted to the tracheo-laryngeal gurgling of the blood and secretions. Some type of suction apparatus should be available, and is best used with a soft rubber catheter with an opening at the end, which is introduced transnasally or orally. A bronchoscopy is occasionally necessary. Often the diligent use of the suction and a semirigid rubber airway suffice to maintain the airway free. Endotracheal intubation is used as an emergency and temporary measure and is tolerated only when the coma is deep. More often the surgeon resorts to tracheotomy, which greatly simplifies the task of aspiration and is life saving.

After ruling out other associated injuries and evaluating the vital signs as mentioned, other, more *strictly neurological* spheres should be explored: pupillary reaction and size, pathological reflexes, cranial nerve signs, etc. The indications for *lumbar puncture* remain somewhat controversial. If not made cumbersome by the patient's restlessness, it has much to commend it primarily because it gives a fairly accurate estimate of intracranial pressure and the extent of bleeding when the simple water manometer is employed.

The importance of *skull radiographs* at the time of the initial examination is again a controversial subject. They may be valuable if not contraindicated by extreme restlessness or a very precarious situation: a fracture that threatens the middle meningeal artery in the floor of the middle fossa may be disclosed thus alerting us to a rapidly developing epidural hemorrhage; depressed fractures with surgical implications are also ruled out, as are deviations of the pineal gland (when calcified) which bear tidings of a space-occupying lesion or cerebral displacement.

Once in the ward, if at all feasible, the unconscious patient deserves the around-the-clock attention of a *special nurse* to maintain a watch on airway, pulse, respirations, blood pressure, etc., and to administer whatever tranquilizers or other medicaments that may be ordered as necessary. *Restlessness*, in particular, can assume proportions such as to constitute a challenge to the patience of the nurse and pharmacological resourcefulness of the attending doctor. Phenobarbital, paraldehyde, chloral, and, more recently the rauwulfia and promazine compounds are used.

Restriction of *fluid intake* seldom plays a role in the management of head injuries except when edema is suspected of acting as a major factor. Otherwise a generous allotment of 2,000 to 3,000 cc of intravenous fluids is administered every 24 hours, including 1,000 of normal saline. If unconsciousness or inability to swallow the recommended complement persists beyond the first two or three days, fluids and nourishment

are administered via an indwelling, thin, polyethylene gavage tube, infrequently dripping portions of a thin liquid diet rated at 1,000 to 2,000 calories daily. Urinary incontinence is best handled by an indwelling, small Foley catheter.

Intractable hyperpyrexia of central origin is another problem requiring assiduous attention. The physical approach in controlling this derangement of the thermo-regulatory centers of the brain, is more rational than the pharmacological, and is based on the principle of giving the subject every chance to dissipate his body heat by exposing the body surface to the room atmosphere, by the use of directly applied cooling devices such as alcohol sponges, sheets soaked in ice-cold water, cold water enemas, as well as rectal aspirin.

Although most serious head injuries run their course without need of surgical intervention, the subdural hematomas and hygromas, and the epidural hemorrhages do make *trephination mandatory*. Steady gradual deterioration in vital signs, increase in focal manifestations, prolonged failure to improve, persistently elevated spinal fluid pressure, bradycardia, hypertension, all join to coax the alert surgeon into exploratory burr holes. These ordinarily are placed in the temporal area, and usually bilaterally in the case of subdural hematomas.

Epidural bleeding is suspected when there is rapid progression of localizing signs, such as homolateral dilated pupil, swelling of the temple and contralateral hemiplegia with deeping stupor, especially if this occurs in conjunction with a homolateral linear fracture running into the floor of the middle fossa. Rapid preparations should be made to expose the epidural space through a quickly enlarged temporal burr hole and a bleeding dural artery can be isolated and silver-clipped or cauterized.

The convalescence and rehabilitation of the head-injured is usually smooth and complete considering the severity of the alteration of brain function that occurred. Pending litigation, a neurotic personality and advanced age are operative in delaying a course of otherwise uneventful recovery, however. The recent tendency to advocate an earlier ambulation and assumption of activity with return to a useful role in life is based on sound principles, and contrasts with the time-honored period of enforced absolute bed rest for the most trivial head injuries, which together with an alarmist and overprotective supervision, often bred much psychosomatic invalidism.

In closing, I should like to be allowed, again, to emphasize the importance of alert, judicious and diligent medical management of head injuries, without detracting from the merits of surgical procedures, which when indicated, can also be life-saving, although best left in the hands of those with the special skills in the field.

2409 E. Adams

RHINOLALIAS

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RHINOLALIAS constitute disturbances of both voice quality and production of the sounds of speech. While each may evidence variations, the two major types of this speech disorder are rhinolalia aperta and rhinolalia clausa. Rhinolalia clausa, also referred to as negative nasality, is characterized by the absence of nasal resonance as required for normal American speech. The result is a "stuffy nose" voice quality and failure in the production of the nasal consonants, "m, n, ng." The latter are the only sounds of our speech properly nasalized and their production requires unobstructed passage of the voice stream posteriorally into the nasal cavity and out via the nares. The most common causes for rhinolalia clausa are nasal polyps, deviated nasal septum, hypertrophied adenoids and nasal congestion due to colds, allergies and any other of the conditions resulting in nasal stenosis.

Rhinolalia aperta, also referred to as positive nasality and by far the most serious of the rhinolalias, is characterized by an unpleasant nasal voice quality and varying degrees of failure in the production of all sounds of speech except "m, n, ng." (Articulation of even these is defective in many severe cases.) The characteristics of rhinolalia aperta arise from an undesired nasal escape of the breath and voice streams of speech. Normal production of the non-nasal sounds of American speech requires that the streams be directed into the mouth and out via the lips. Moreover, all such sounds except the vowels and semi-vowels require considerable oral pressure since they are produced with hissing, explosion and other pressure actions. And in order to pressurize the oral cavity for these actions, measures must be taken to prevent posterior escapes of the speech streams into the nasal cavity. Structures which prevent this escape are the velum and adjacent portion of the pharyngeal wall, making up what is referred to as the nasal port. In normal production of the nasals, "m, n, ng," this port is open, while in production of all other sounds it is closed by the levator action of the velum and the constricture action of the pahryngeal wall.

Possible causes for rhinolalia aperta are paralysis of the velum and/or the pharyngeal wall, cleft palate, cleft velum, atrophy of the posterior palatine or of the pharyngeal nerves, post-adenoidal conditions, low energy level which renders the individual incapable of the vigor required for velo-pharyngeal closure, foreign or regional dialect, and congenitally widely separated velum and pharyngeal wall. Commonly active, too, is residual cleft palate or velum in which the velum is too short for its function in velo-pharyngeal closure or in which the defective speech patterns previously established persist as a now purely functional disorder.

Post-adenoidal rhinolalia aperta merits special discussion. There are two degrees of this type of positive nasality: (1) the relatively mild and temporary condition which usually follows a T and A and which is due to the post-traumatic state of the velo-pharyngeal structures, and (2) the more serious type which requires speech therapy, and possibly surgery, for correction. The more serious type originates as rhinolalia clausa due to complete nasal stenosis induced by hypertrophied adenoids. During such a severe stenosis, velo-pharyngeal closure of the nasal port ceases because obviously it is no longer necessary. If such a deactivation continues long, it is lost as a speech function and continues so even after adenoidectomy, with the result that the voice and breath streams of speech now flow unimpeded into and out of the nasal cavity. The speech picture of such a condition is comparable with that of unrepaired oral clefts, velar paralysis or any other of the causes cited as possible etiological factors in severe rhinolalia aperta.

Methods, as well as success, in correcting rhinolalias depend upon cause, age of the individual, his speech "sense," general intelligence and his motivation in the therapeutic procedure. Correction of the clausa type usually can be accomplished by successful medical or surgical treatment of the stenosis. Exceptions are those cases which possibly may result in conditions similar to that of post-adenoidal rhinolalia aperta.

Rhinolalia apertas pose a more difficult problem. In velar paralysis such as that suffered by the cerebral palsied child or the older victim of apoplexy, often only limited improvement may be achieved even with extended periods of speech therapy. Those cases due to low energy level will yield little until factors of health have been treated and those caused by widely separated velum and pharyngeal wall or severe post-adenoidal conditions may not yield without surgery of a nature to be discussed later. On the other hand, the relatively mild apertas due to regional prevalence, foreign dialect or others of imitative origin may yield quite readily to speech therapy.

The most common, as well as the most serious, types of rhinolalia aperta are those of the congenital cleft palate and velum (combined or separate, the patient is commonly referred to as a cleft palate). These usually are accompanied by aesthetic, and therefore psychological, as well as physical complications in addition to oral clefts. These include clefts of maxilla and upper lip, causing articulatory difficulty with specific sounds of speech, clefts of nares, missing or deformed pinnae, absence of apertures into the external auditory meatus and, even in normal external auditory structures, marked hearing loss.

As is the case in many speech disorders, the speech pathologist must work in close conjunction with the physician in treating oral cleft rhinolalias. Though there are occasional reasons for exception, speech therapy ideally is begun only after closure of all clefts. If surgery has rendered oral structures adequate for normal speech, achievement of normalcy is a possibility with varying lengths of speech therapy. Relative statistics are unavailable, but the unfortunate fact is that many cleft palates must undergo speech therapy regardless of the degree of success of surgery. While rhino- and labioplasty may be completed during the few weeks of life, palato- and veloplasty generally are deferred until the 18th month. Such a pattern has been established because oral tissue is more amenable to surgery at this time and because the rate of mortality is considerably higher at earlier ages.

As early as 18 months may seem, it is late so far as speech is concerned. Many children of this age have developed a great deal of (defective) speech, and despite lack of audible evidence others have nevertheless undergone certain developmental stages in the form of neurograms and muscular patterns. Any alalic will have undergone such development by 18 months, but in the cleft palate these neurograms and muscular patterns have been suited to the defective structures existant prior to surgery. Following successful surgery it is said usually that oral structures are now adequate for normal speech. The more accurate statement, however, is that they are potentially adequate, for actual achievement may depend upon long periods, often years, in which the speech therapist must tear out by the roots all defective, reflexive speech patterns and insert normal ones in their place.

The cleft palate faces another problem. Though plastic surgery has closed all clefts, it has been pointed out earlier that the velum may be unable to function in velo-pharyngeal closure because of insufficient length or because of neural or muscular atrophy. Only a few years ago these patients had to be content with only moderate improvement even after considerable speech therapy. Speech normalcy was in fact never achieved. Recently, however, a surgical procedure has been developed to meet the need of the inadequate velum. This surgery, called a pharyngeal flap procedure, makes speech normalcy possible for every patient whose clefts have been closed. In this procedure the plastic surgeon fashions a tissue flap on the pharyngeal wall and brings it forward to be surtured to a prepared portion of the velum. Variations of the procedure are the superior, in which the flap is sutured to the oral portion of the velum, and the inferior in which it is sutured to the nasal portion. In either case the result is a nasal port composed of two lateral apertures separated by the newly formed flap. Closure of the port is now achieved by constricture of the pharyngeal wall against the flap. The apertures are sufficient for nasal drainage and, by testimony of two adults and a 14-year-old, the change in oral structure poses no discomfort. In six such cases rendered speech therapy by the writer, four experienced sudden, spontaneous and dramatic speech improvement, one is slowly but consistently making progress of which he was totally incapable prior to surgery and the sixth evidenced no spontaneous improvement and has as yet undergone insufficient therapy to determine the ultimate outcome. This

surgical procedure may be applied also in cases of widely separated velum and pharyngeal wall and in severe post-adenoidal rhinolalia aperta. Surgery for the latter condition is presently pending for two cases, the only ones of this type of disorder which in the writer's experience have failed to respond to therapy. How universally the pharyngeal flap procedure is used is unknown. It is eventually certain, however, to replace the velar obturator, which incidentally the writer has never recommended nor seen used successfully. The only such oral prosthetics he has seen used successfully were those fitted into apertures remaining in the bony palate.

Candidates for the pharyngeal flap procedure fall into three classifications: (1) those who at first examination definitely can be said to require it, (2) those who as readily can be said not to and, (3) those questionable cases which require a trial period of speech therapy before the need can be determined. Final decision for the procedure is a joint function of the plastic surgeon and the speech pathologist. Appearance of the velum can be confusing to one newly introduced to this problem. A velum which has normal appearance may be totally inadequate from a functional standpoint, while one which is alarmingly short and misshapen may have completely normal mobility and function. Clues which determine wisdom of the procedure are (1) the patient's ability to perform successfully particularly suited blowing exercises, (2) his ability to produce the isolated sounds of speech and (3) the mobility of his velum in mechanically induced gag reflex. Successful performance of any one of these renders the pharyngeal flap procedure unnecessary. The decision in favor of this last resort procedure is to be taken no more lightly than other types of surgery, but only after carefully weighing the possibilities of normal speech achievement without it. The only reason for the step in case of doubt is that the patient lives in an area where speech therapy is unavailable and there is strong possibility that surgery alone will enable him to achieve spontaneous improvement.

Correction of any severe aperta is difficult. One of the most difficult problems faced by the speech therapist, however, is correction of those arising from cleft palate or velum. These cases are not candidates for group therapy and a great deal of experience is necessary in the therapist if he is to achieve correction even in private therapy. In simplest terms, the problems faced are activating the nasal port, of whose function and existence the patient is wholly unaware, and securing reflexive speech movement of all oral structures previously used defectively or not at all in the speech process. In the writer's experience development of normal speech in such cases has required from 18 to 30 months, depending upon the degree of failure involved. Speech therapy for the repaired cleft palate may begin as early as two and one-half years and should not be delayed beyond age three. In rhinolalias as well as other speech disorders, the longer therapy is delayed the more entrenched defective habits become and the longer, more difficult and expensive the therapeutic procedure.

SUMMARY. Rhinolalias are combined disturbances of quality of voice and production of the sounds of speech. Major types of these disorders are rhinolalia aperta and rhinolalia clausa. Symptoms of the latter are a "stuffy nose" voice quality and, in severe cases, absence of the nasal consonants, "m, n, ng." Causes of these symptoms are nasal stenoses which prevent nasal escape of voice as required for American speech. Rhinolalia clausas usually can be corrected by medical or surgical treatment of the stenoses.

Symptoms of rhinolalia apertas are a nasal voice quality and varying degrees of failure in production of all sounds of speech except "m, n, ng." Causes of these symptoms are oral paralysis, cleft palate, post-adenoidal conditions and other disorders which prevent velo-pharyngeal closure and consequent nasal escape of all speech efforts. Steps in correcting rhinolalia apertas may include velo- and plato-plasty, speech therapy and possibly pharyngeal flap surgery, a recently developed, last resort surgical procedure for cases in which the velum is inadequate despite previous surgery.

Most rhinolalics can achieve normal speech if services of the physician, the plastic surgeon and the speech therapist are sought early.

FROZEN SECTIONS

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ONE USE of the frozen section will be mentioned very briefly. This indication is the occasional need for one of the relatively few special stain preparations which cannot be secured if the tissue has been dehydrated and blocked in paraffin. The other indication is a situation which may (or may not) be found to exist when a fresh surgical tissue is presented with the question: Are we dealing with cancer? There has been, and still is, much disagreement regarding the use of the quick frozen section in such circumstances. At the one extreme, it has been maintained by such workers as McCarty, McDonald and Culp, and Dockerty, that properly prepared frozen sections are as reliable as permanent paraffin sections. At the other extreme, such individuals as Ewing, Warthin, Simpson and Breuer have been extremely dubious regarding their usefulness. The role played by Bloodgood in this connection is particularly interesting. For quite a long time, Bloodgood highly recommended the frozen-section-at-operation; however, finally, this individual completely reversed his attitude and recommended – if the lesion could not be readily (grossly) identified as cancer – that the wound be closed and that nothing more be done until a positive diagnosis became available following careful study of routine sections. At the present time, the vast majority of practicing pathologists believe that the quick frozen section does serve a useful function, but that the limitations of the frozen section method need to be fully appreciated. Even in the most expert hands, the tissue being subjected to adequately prolonged preliminary fixation with formalin, the frozen section is not consistently equal in quality to the routine paraffin section. The difference in quality is such as to make mandatory this rule: *If the gross "picture" is not such as to suggest very strongly that the lesion is cancer, do not permit the findings with quick frozen section to modify the initial impression that the lesion is benign.* Exactly the opposite rule holds with the routine paraffin section. With the paraffin section, the lesion which appears grossly benign can safely be reported malignant, the revised opinion being based purely upon the histologic findings. Another limitation as regards the frozen section technique is the fact that certain tissues are processed rather readily, whereas others are not. There are case exceptions: more often than not, however, the frozen section provides no useful information if we are dealing with one of the malignant lymphomas. Papillary neoplasms are not readily typed by means of frozen section. All tissues (and lesions) which are grossly friable, mucinous or hemorrhagic fall into much the same category. The method is rarely useful if the lesion is of non-invasive (in-situ) type.

At the present time, in this hospital, tissues delivered to the pathologist during the course of a surgical operation are ordinarily handled in one of two ways. If the surgeon has asked simply for "diagnostic study" or for "consultation," the question being one of cancer, the pathologist has considerable choice as regards method or methods of analysis. If gross examination reveals no sign of cancer, this is immediately reported; considerable time is saved. If gross dissection of the specimen reveals a lesion which appears as cancer, recourse may be had to frozen sections, or (if the lesion is extremely soft and friable) to so-called "contact smears." "Contact smears" are occasionally, in selected cases, much more useful than frozen sections, A different situation evolves if the specimen is delivered to the pathologist with the specific direction: "Make a frozen section." It is appreciated that the specific demand for frozen section is sometimes a direct reflection of instructions given the surgeon by the patient. The patient who insists on directing his or her program of diagnosis and therapy is, – of course unintentionally, – severely handicapping the physician (or physicians) who might otherwise be able to exercise judgment predicated on findings. In such a situation, when there is no option, if dissection of the specimen reveals no lesion which appears as a focus of probable malignant neoplastic change, it is necessary quite haphazardly

Presented – Staff Meeting – St. Mary's Hosp., Tucson, Ariz., May, 1957.

to select a block of tissue from which to cut frozen sections; the "picture" presented by such a section has to be staunchly ignored; if the lesion "looks like" cancer, it is probably sclerosing adenosis. The "frozen committment" has one possible advantage; it unquestionably increases the number of cases subjected to frozen section and helps the pathologist to keep in practice. On the other hand, however, it intensifies the one great hazard encountered by those who use the frozen section method; this hazard is the persistant temptation to attach too much significance to the frozen section "picture." At a seminar held this last October (1956) in Chicago, following mention of an extremely rare lesion, adenocarcinoma arising in fibroadenoma of breast, and a suggestion that this finding might encourage the pathologist more frequently to subject lesions which appear as fibroadenomas to quick frozen analysis, one of the most reputable pathologists in the country had this to say: "I think that it is still good policy not to do a frozen section on the garden variety of fibroadenoma." No opinion to the contrary was expressed. In one of the newest textbooks of pathology, one of the best such tomes presently available, Dr. Lauren V. Ackerman has this to say about quick frozen sections: "In cancer, there are only three possible diagnoses, positive for cancer, negative for cancer, or no diagnosis made." In practice, the quick diagnosis "positive for cancer" means ordinarily that the tissue contained a lesion obviously grossly cancer and that this diagnosis has been confirmed by study of a frozen section. On the contrary, the diagnosis "negative for cancer" means simply that cancer could not be identified with the naked eye, or with frozen section — one or more haphazardly selected blocks of tissue being examined. The immediate "negative for cancer" report provides no assurance that exhaustive follow-up study of a series of routine paraffin sections will not reveal the presence of occult cancer.

During a recent period of 18 months, 398 surgical tissues were subjected in the laboratory of this hospital to immediate diagnostic study. A recently published analysis by Jennings and Landers tabulates the results of analysis of 412 surgical tissues during a period of 18 months. During a period of 30 months, 620 surgical tissues submitted for immediate diagnostic study were processed in the laboratory of this hospital. In the Jennings and Landers series, 212 of the examinations were breast biopsies; in this series (collected during 30 months) 406 of the examinations were breast biopsies. In 384 instances (94.5 per cent), a definite diagnoses of cancer was rendered in 68 instances and it was reported in 316 instances that no evidence of cancer was detected. In 22 instances (5.4 per cent) the nature of the lesion was doubtful and the surgeon was advised to await the permanent sections. In two cases (0.49 per cent) occult carcinoma (the lesions not being grossly detectable) was discovered as routine paraffin sections were studied. These percentages check very closely with those reported by Jennings and Landers; no other similar analysis is found in the current literature.

It is a well known fact that the thyroid gland rather commonly presents lesions of such a nature that the differentiation of benign from malignant processes is difficult when one is given an opportunity to make a time-consuming study of technically excellent routine paraffin sections. For this reason, the average pathologist attempts a frozen section of thyroid gland with considerable reluctance. In at least one of the medical school affiliated departments of surgical pathology, no attempt is made to cope with lesions of the thyroid gland employing the frozen section technique. In the present series, an examination of this type was requested and carried out in the instance of 36 tissues. The results (Table II) were good in that all immediate definite reports were confirmed; however, the fact that results were doubtful in 33.3 per cent of instances supports the concept that the method is not very satisfying when the tissue is thyroid gland.

The remaining 178 tissues (see Table III) were, with few exceptions, submitted with a requisition for "frozen section," the pathologist being given no option as regards diagnostic methods to be employed. There was, in this group, some concentration of tissues not suitable for frozen section analysis. As might be anticipated, there was a fairly high incidence (15.7 per cent) of doubtful results. However, occult cancer was found only once (0.57 per cent). These tissues were quite various in origin and included material identified as uterine scrapings, uterine cervix, body of uterus, ovary, testis, epididymis, urinary bladder, lymph node, skin, subcutaneous tissue, axilliary tumor, re-

TABLE I – BREAST CANCER? 460 tissues

Frozen section diagnosis	Yes 68		No 316		Don't know 22**	
Final diagnosis	Yes 68	No 0	Yes 2*	No 314	Yes 12	No 10

*0.4% **5.4%

TABLE II – THYROID CANCER? 36 tissues

Frozen section diagnosis	Yes 3		No 0 21		Don't know 12	
Final diagnosis	Yes 3	No 0	Yes 0	No 21	Yes 1	No 11

TABLE III – CANCER? Miscellaneous group – 178 tissues

Frozen section diagnosis	Yes 58		No 92		Don't know 28	
Final diagnosis	Yes 58	No 0	Yes 1	No 91	Yes 15	No 13

TABLE IV – CANCER? Results with entire group

Definite immediate report ("cancer" or "no cancer detected") later confirmed	555.	(89.5 per cent)
Immediate report "Don't know"	62.	(10.0 per cent)
Occult cancer (not immediately recognized or suspected, later reported)	3.	(0.48 per cent)
Total	620.	

troperitoneal tumor, "adrenal," lip, salivary gland, stomach, pancreas, small intestine, vermiform appendix, large intestine, liver, bile duct, gall bladder, abdominal mass, nasal mucosa, lung, brain, etc.

Table IV indicates the results with the entire group, 620 tissues.

In summary, present methods of routine paraffin processing (using one of the robot mechanisms) makes possible procurement of paraffin sections very promptly, – as promptly as frozen sections if the tissues are first adequately fixed. Without adequate fixation, consistently good frozen sections cannot be secured. Even with adequate fixation, frozen sections are more frequently than not unsatisfactory if a really interesting (perplexing) problem is encountered. Excluding the occasional special stain problem, the only present need for the use of the frozen section technique is in those cases where preliminary gross examination of a fresh surgical tissue (examined while the patient is in the operating room and under anesthesia) reveals the presence of a lesion which is almost certainly cancer. In such circumstances, its limitations being fully appreciated, the frozen section plays a useful role in the diagnosis of cancer.

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EARLY SUPPRESSION OF POSTOPERATIVE BILIARY DRAINAGE*

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THERE seems to be a tendency to disregard those postoperative drainages which follow surgery, exemplified by cholecystectomies, as of normal occurrence. Few therapeutic measures are employed to protect patients against the loss of such valuable fluids postoperatively which are allowed to saturate their abdominal dressings. Few papers have appeared to focus attention of surgeons on the rectification of this highly important matter. The marked loss of such fluid, through prolonged exudation, can very well impede the patient's convalescence. Furthermore, the protracted loss from severe biliary drainage of these precious fluids can easily produce dehydration, hypoproteinemia, and a definite upset in the electrolytic balance(1), (2), (3).

Surgical intervention initiates an inflammatory reaction of tissue in this surgical area. Christopher wrote that the surgeon produces some degree of inflammation with every stroke of the knife(4).

The five well known signs of inflammation are heat, swelling, pain, redness, and loss of function. The formation of the exudative reaction in inflammation is exemplified by omnipresent swelling, which is, in reality, the production of edema(5). If this inflammatory tissue fluid escapes the body it is termed an exudate(6). The production of such an inflammatory response is due, at least in part, to increased capillary blood pressure during the hyperemia (active) stage because of increased capillary permeability which transfers the osmotic pressure from inside to outside the capillary walls(7). In recent clinical observations, we have found there is a decided rise in venous pressures in such edematous surgical areas through the indirect and the direct measurements of venous pressures(8). Apperly wrote that "clinical edema is usually not due to any one single factor but to a combination of several factors(9), which include the cognizance of capillary blood pressure, the protein osmotic pressure, capillary permeability, lymphatic drainage and various nervous influences." Of these various factors, perhaps increased capillary blood pressure (plus increased venous pressure) and the increase of capillary permeability are the most important factors which are concerned with the formation of clinical edema.

Some workers have looked upon edema formation as the body's attempt to cleanse the involved area of noxious or toxic substances. Hence, they feel that edema formation flushes away these poisonous materials. Although this concept is probably partially correct, an injury of the hepatic tissues also may produce an attempt on the part of viable liver tissue to flush away noxious substances through the increased production of an excessive flow of bile. Most surgeons have witnessed the marked exudation of bile through a drainage wound. The usual postoperative procedure is to reinforce the massive abdominal dressings which have been placed over the surgical site in order to catch and to absorb this marked increase of bile flow. Various drains are placed in the surgical area during surgery to expedite this postoperative biliary discharge. It is thought that allowing such an increased bile flow to escape the body freely decreases the pressure which might occur if such a drain were not employed as a safety valve.

A tremendous discharge of bile often occurs. This increased biliary discharge is accompanied by the inevitable and dangerous loss of electro-

*From the Department of Medico-Surgical Research, Roslyn Park Hospital, Roslyn Park, Long Island, New York.

lytic fluids, proteins, water and hematogenous materials which can be only replaced, at least partially so, by repeated and costly blood transfusions. *We deem it of prime importance to suppress, if at all possible, or to prevent the rapid and dangerous loss of such biliary discharges at the very earliest opportunity.* We think the suppression of such discharges helps the body economy in many important ways. Dehydration, through the loss of such fluids, can be prevented. Proper and more rapid wound healing can be observed as can the conservation of important blood elements and many other life-sustaining substances which are connected intimately with the healing processes and even the preservation of life itself.

Several years ago, a study advocated the suppression of those lochias which invariably follow childbirth(10). It was found that much better wound healing resulted from this procedure, and the mothers' convalescence periods were lessened markedly.

As with the loss of fluid from various wound discharges, attention must be given to fluid loss which results from bleeding, operative and post-operative. Martin(11) recorded "the incision is the commonest site of postoperative bleeding in abdominal operations. Careful control of all bleeding on opening the abdomen is not only desirable but essential. There frequently continues to be an ooze, even with care, both during the procedure and at the termination of the operation. A rapidly developing hematoma may account for wound infection, which interferes with the process of healing. This is accepted as one of the important factors in causing dehiscence or an incisional hernia."

We discovered, through prolonged observation, that this incisional oozing is capillary in origin. Its adequate control can be affected readily by using Kutapressin which is administered preoperatively. This material constricts the dilated microcirculatory components which produce such blood oozing during and after surgery. On many occasions we have noted that the incisional area appears to be considerably more dry than it would have been had not the above constricting agent been employed.

Such oozing of blood at surgery and after can be compared also to the fluid loss which ensues from wound drainage. As a matter of fact, both are quite similar in many ways. Hence, their adequate control becomes mandatory to influence proper wound healing and to prevent operative shock with Kutapressin therapy. "The surgeon at the operating table becomes aware of the development of shock by the reduction in capillary bleeding and darkening of the venous blood. Arterial blood remains bright as long as the respiratory mechanism is not disturbed,"(12) for fluid loss from hemorrhage during surgery is capable of producing shock.

A peculiar attitude was observed on the part of the many colleagues who discussed this obstetrical report. They could not understand why a "perfectly normal" post-partum reaction, as exemplified by the presence of lochias which invariably follow childbirth, should be suppressed or even advocated. According to some colleagues, we were interfering with a normal reaction or bodily response which naturally follows childbirth. Hence, the suppression of such fluid must, in some way, interfere with nature's normal response to injury. They refused to accept our suggestions for suppressing such fluid losses, and they regarded our constrictive therapy as a form of meddling in the normal processes which are connected with modern midwifery. We were unable to comprehend this reactionary attitude.

Our current study advocates the rapid suppression of post-operatively biliary discharges. Besides the reasons for controlling these discharges, which have been mentioned heretofore, the patients themselves welcomed this procedure. Massive abdominal dressings, which become soaked with such unpleasant biliary drainages, have the tendency to stick to the surgical areas, and thereby making such patients highly uncomfortable and quite unhappy, not to mention the protracted periods of convalescence which this undesirable and currently routine procedure produced by this widely used practice.

Years ago, surgeons thought of pus as being "laudable" for its mere presence was hailed as a good sign which was desirable for the proper healing of wounds. By the same token, and although pus is no longer "laudable," many surgeons still regard copious biliary drainages as being necessary to help clean out surgical wounds which follow gall bladder surgery. Such a concept should be condemned vigorously. To that end, we shall present the following therapeutic measures to suppress such copious biliary discharges which follow such surgery.

The Method

Vasoconstriction of the microcirculatory components in these biliary areas tends to limit the flow of such biliary drainage. From long experience, we have found this measure can be effected quite safely and efficaciously through the use of a non-toxic, injectable derivative from crude liver. The trade name of this preparation is Kutapressin.*

Our usual pre operative procedure, in order to control the pronounced capillary bleeding which at times accompanies surgery of all types, is to administer two cubic centimeters of Kutapressin subcutaneously about one hour before surgery is performed. Other pre-operative medications are administered concomitantly but with separate syringes and in the opposite arm of the patient.

As the patient begins to convalescence following surgery, another two cubic centimeter dose of Kutapressin is administered twice daily. We have observed both a rapid cessation of biliary drainage, plus a more rapid healing rate for such postoperative wounds with the use of this material. There are no known contraindications for the use of this microcirculatory constricting preparation which we employ to tamponade capillary bleeding and also tissue drainage.

Postoperative Results and Observations

Twelve patients constituted the *experimental group* which received injections of Kutapressin subcutaneously twice daily (morning and evening) in 2 cc. doses. The control group of 12 patients were not given Kutapressin at any time.

The main items for comparison between the *experimental* and the *control* groups were (1) the amount of biliary drainage (2) the amount of capillary bleeding and (3) the rate of wound healing in these two groups of patients.

		Am't. Capillary Bleeding At Surgery	*Postoperative Day Biliary Drainage Ceased*	*Postoperative Day Wound Healed*
Without Kutapressin	Control Group	Moderate	7th to 32nd day	14th to 38th day
With Kutapressin	Experimental Group	Slight	1st to 4th day	9th to 18th day

Experience has proved that, although there is a marked difference in these two groups, it is mandatory to continue twice daily injections of Kutapressin until the patient's wound is entirely healed. A too early discontinuance of such injections causes the postoperative discharge to reappear. This presence of such biliary discharge will then be observed reaidly on the patients' abdominal dressings.

We desire to again direct the attention of our readers to the fact that these postoperative biliary discharges are controlled through the constriction of the dilated microcirculatory components in such a surgically involved area. Since Kutapressin's pharmacologic action does not last indefinitely, it is very necessary to continue the twice daily dosages until the wound becomes healed properly and firmly.

A similar control of lochial discharges had to be continued also with daily Kutapressin injections as had those serious drainages which were observed with extensive burns and with certain diseases of the integument as noted in cases with poison ivy and the exudatory dermatoses, and wherever marked exudates (discharges) occurred with other diseases.

Recently, the question arose as to controlling the marked fluid losses which accompany those acute idiopathic diarrheas in infancy through capillary constriction. Upon first thought, this idea may strike the reader as being a bit farfetched. However, when one recalls the marked dilatory state of the microcirculatory ailmentary components in most cases with dysentery, it appears quite rational to vasoconstrict these dilated terminal vessels which supply the diseased and dilated intestinal microcirculatory system. Consequently, we have been using Kutapressin, in one cc. doses, for the treatment of such idiopathic acute infantile diarrheas with decided success. The reader should recall that those

*Kutapressin is manufactured by the Kremers-Urban Company of Milwaukee. This injectable material exerts its pharmacologic effect by constricting the dilated microcirculation which accompanies all forms of inflammation of tissues and organs. This preparation does not raise the systemic blood pressure. The material is non-allergenic, and it is practically painless upon injection.

marked fluid losses which accompany such disorders are merely another form of exudation.

Case Histories Involving Postoperative

Biliary Discharges

Two seperate cases will be described to demonstrate the marked difference we noted with and without Kutapressin therapy. The first patient was a middle-aged male who underwent a cholescystectomy for the removal of a large solitary gall stone. This patient had complained of a generalized malaise which was accompanied by periods of chills with sweating. The night prior to admission in the hospital, he complained of a severe intense, sharp and constant pain in his gall bladder area. Opiates in large doses were needed to control the pain which was accompanied by partial shock. He remained in the hospital two weeks prior to surgery in order to prepare him for a cholecystectomy. Following surgery, he discharged a copious amount of bile-colored drainage in his abdominal dressings for a matter of 32 days. His general convalescence was very slow and the incision did not heal well so that the area became scarred badly.

In contradistinction to the above case another middle-aged patient exhibited a similar solitary gall bladder stone which was removed with a Collins-Thorek approach to the surgical area. The patient was given 2 cc. dose of Kutapressin an hour prior to surgery, and a similar dose during the afternoon of surgery. This procedure was repeated twice daily without interruption. His wound discharged bile through the Penrose drain for only two hours after he returned from the operating room. The drain was removed the third postoperative day, and the surgical area was completely dry and remained so throughout the period of his convalescence which totaled two weeks. The wound was very firm and without a hypertrophic scar. His original dressing had been changed on the third postoperative day when the drain was removed. Not enough biliary discharge escaped to stain his abdominal binder at the time this first dressing was changed. This wound remained completely dry when all dressings were removed on the 14th postoperative day. No further surgical dressings were necessary. This patient showed a much smaller amount of postoperative drainage than is usually the case with Kutapressin therapy. However, with this new technic, those patients in the experimental group have been able to conserve those highly important hematogenous elements which would have been lost through soaking of the surgical dressings, had not this new form of therapy been employed. The rapid convalescence in this series of patients was uneventful (experimental group).

The following cases were taken from another series of patients which were not included in the control and experimental groups which have been described heretofore.

Case 1. Mrs. G. H. aged 45, housewife, entered the hospital because of a duodenal fistula following a gastrectomy performed elsewhere one month prior to present admission. Admitted because her family physician became concerned over the bile drainage. After surgical consultation, surgery was deferred pending the administration of Kutapressin. The drug was used and the drainage stopped in one week.

Case 2. Mr. W. H. aged 30 had a cholecystectomy. On the third postoperative day bile emanated from the wound. The operating surgeon asked for a consultation prior to a reoperation for what he believed to be bile flow from the cystic duct secondary to a slipped ligature. Consultant advised Kutapressin and the bile drainage ceased in five days.

Cases 3 and 4. In two instances where the common duct was explored and a T tube was inserted in the common duct, Kutapressin was given immediately, and drainage stopped 36 hours following removal of the T tube.

It might be very expedient to remember constantly that all discharges, no matter where their origin, constitute integral and important components of the process which is known as metabolism. To disregard and do nothing about such losses is to place the patient in jeopardy, particularly if those elements, which have drained from the patient, are not replaced properly and promptly. But far more preferable would be the institution of immediate measures which could prevent such losses. This concept and method then, constitutes the main premise of this paper. *We urge the conservation of these life-sustaining fluids through the proper vasoconstriction of the dilated microcirculation in all surgical areas.* The specific pharmacologic action, through the twice daily administration of Kutapressin, will fulfill the clinician's wishes for the immediate control and prevention of fluid losses which are illustrated by all un-

desirable postoperative biliary discharges.

We have discussed the problem of biliary discharges with other surgical colleagues, whose reactions seemed to be based upon their personal preferences as to the type of incisions they preferred and the amount of biliary discharges their own technics produced. Perhaps in no specialty is the presence of individuality more pronounced than it is with surgeons. Some surgeons feel their personal technics are the best and other methods will not suffice as well as do those methods which they employ.

Graduates of a particular medical school appear to adhere to those teachings they receive while students. Other surgeons will prefer the technic which they were taught during their residencies. One particular surgical colleague informed us that his biliary patients never exhibited such troublesome discharges postoperatively as we have discussed during the course of this paper. But upon examination of his actual handicraft, it became apparent that at least one of his patients unfortunately exhibited an intense biliary discharge which persisted for many weeks.

It appears quite obvious, therefore, that such troublesome postoperative biliary discharges do occur in spite of certain well established surgeons' claims that they rarely see such a postoperative complication. The fact remains that this postoperative sequela is in need of prompt rectification. A sincere trial of our proposed method will soon verify or disprove our thesis that such biliary discharges can be controlled promptly, efficaciously and safely through the constrictive pharmacologic control of the dilated microcirculation in such surgical areas.

Summary

A new therapeutic approach for the control and elimination of postoperative biliary discharges is described in detail. Use is made of Kutapressin, a non-toxic and non-allergenic derivative produced from liver which possesses the happy property of constricting the dilated microcirculatory components in postoperative biliary areas without raising the systemic blood pressure. This material is administered subcutaneously in 2 cc. doses twice daily. Both the dosage can be increased and the time of administration can be lessened whenever the condition of the patient warrants such a change in order to control these postoperative biliary discharges adequately. The important and practical reasons for employing this new procedure are discussed at length.

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The President's Page

MAY I EXTEND GREETINGS AND BEST WISHES TO THE UNITED STATES AND MEXICO, IN DECEMBER 1957. THIS YOUNG AND VERY VIGOROUS SOCIETY DESERVES THE ACTIVE PARTICIPATION OF ALL MEMBERS OF THE ARIZONA MEDICAL ASSOCIATION, NOT ONLY FROM A PROFESSIONAL STANDPOINT, BUT CULTURALLY AND SOCIALLY AS WELL.

I URGE ALL OF YOU TO ATTEND.

SINCE THE ASIAN FLU VACCINE HAS BECOME AVAILABLE IN VERY LIMITED SUPPLY, THERE HAVE BEEN ALL SORTS OF RUMORS, INCLUDING BLACK MARKET. MOST OF THESE RUMORS WHEN RUN DOWN ARE ONLY THAT. FOR INSTANCE, ALL EMPLOYEES OF ONE STORE IN PHOENIX WERE GIVEN THE FLU VACCINE. IT IS TRUE THAT THEY WERE GIVEN FLU VACCINE, BUT IT WAS OLD A & B, NOT THE ASIAN.

OUR GOVERNOR HAS STATED THAT HE WOULD TRY TO FIND SOME METHOD BY WHICH HE COULD HAVE THE STATE HEALTH DEPARTMENT TAKE OVER THE DISTRIBUTION OF THE VACCINE IN THE STATE. THE STATE HEALTH DEPARTMENT DOES NOT WISH TO BE CAUGHT IN THE POSITION IT WAS WITH THE POLIO VACCINE. IT IS MY OPINION THAT THE PRIVATE DISTRIBUTION IS THE BEST METHOD. ANOTHER SOURCE OF IRRITATION HAS BEEN THE PRACTICE OF THE DETAIL MEN OF TAKING ORDERS DIRECT FROM PRIVATE FIRMS AND THE SAME ONES ARE ALSO SHIPPING TO THE PRIVATE FIRMS AND TO SOME DOCTORS, BY-PASSING THE WHOLESALE AND RETAIL OUTLETS.

I WOULD RECOMMEND THAT ALL DOCTORS DO THE BEST THEY CAN TO COMBAT THE HYSTERIA THAT HAS BEEN BUILT UP IN THE PUBLIC PRESS AND DO EVERYTHING THEY POSSIBLY CAN TO ALLOW PROPER DISTRIBUTION THROUGH NORMAL CHANNELS. IF PROVED INCIDENTS OF BLACK MARKETING CAN BE OBTAINED, I WOULD SUGGEST THAT THE GRIEVANCE COMMITTEES OF YOUR COUNTIES TAKE PROPER AND PROMPT ACTION AGAINST THE VIOLATORS.

C. C. CRAIG, M.D.
PRESIDENT
ARIZONA MEDICAL ASSOCIATION, INC.

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ACHRO

THERAPEUTIC BLOOD LEVELS ACHIEVED

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Editorial Page

ARIZONA MEDICINE

Journal of
ARIZONA MEDICAL ASSOCIATION, INC.

VOL. 14 NOVEMBER, 1957 NO. 11

CONTRIBUTORS

The Editor sincerely solicits contributions of scientific articles for publication in ARIZONA MEDICINE. All such contributions are greatly appreciated. All will be given equal consideration.

Certain general rules must be followed, however, and the Editor therefore respectfully submits the following suggestions to authors and contributors:

1. Follow the general rules of good English, especially with regard to construction, diction, spelling, and punctuation.
2. Be guided by the general rules of medical writing as followed by the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.
3. Be brief, even while being thorough and complete. Avoid unnecessary words. Try to limit the article to 1500 words.
4. Read and re-read the manuscript several times to correct it, especially for spelling and punctuation.
5. Manuscripts should be typewritten, double spaced, and the original and a carbon copy submitted.
6. Articles for publication should have been read before a controversial body, e.g., a hospital staff meeting, or a county medical society meeting.
7. Exclusive Publication—Articles are accepted for publication on condition that they are contributed solely to this Journal. Ordinarily contributors will be notifed within 60 days if a manuscript is accepted for publication. Every effort will be made to return unused manuscripts.
8. Illustrations — Ordinarily publication of 2 or 3 illustrations accompanying an article will be paid for by Arizona Medicine. Any number beyond this will have to be paid for by the author.
9. Reprints — Reprints must be paid for by the author at established standard rates.

The Editor is always ready, willing, and happy to help in any way possible.

(The Opinions expressed in original contributions do not necessarily express the opinion of the Editorial Board.)

PREPAREDNESS

OVER SEVEN years, since the start of the Korean war, there is still not a satisfactory civil defense organization in our state. Arizona lags behind in efforts to properly protect its people. Much of this is an outgrowth of a tendency to use hackneyed politicians or part-time C.D. employees. There is no organization to evacuate our people from the major communities and establish aid facilities in the outlying districts.

What have we established on a state level? Very little. Are there mobile hospitals available? Certainly, there should be two immediately available in this state, with the number that have been issued throughout the nation. Is there co-ordination with the public health department? None, to the best of my knowledge. What steps have been taken by civil defense and the public health department to establish a program to be followed should a catastrophe occur? None, to my knowledge.

What alarm system is available in Tucson to permit these people to evacuate this target site, the home of Hughes Falcon Plant and Davis-Monthan Air Force Base? None, even though many steps and many comments have been made that these systems were forthcoming.

What effort has been made to integrate the programs of the various cities of the state, or the various cities of the Southwest? None. These are steps that cannot be taken after the bomb drops, or the missile arrives. There must be an alerting mechanism. There must be a warning system, an evacuation program, and then an effort made to care for the people once they are evacuated. It is not a hopeless situation. It is a desperate situation.

How many of you have attended a civil defense preparedness program or meeting in your community? If you have, you have attended one of the most poorly organized meetings with little evidence of foresight or imagination. Chaos in a meeting! How can confusion from the C.D. organization lead to anything but disorder, if the people look to that organization for leadership in case of an emergency?

When will those of you who are responsible for the medical care of the people of this state become so dissatisfied that you will demand a more efficient organization with potential

powers that can move when the necessity arises?

D.W.N.

"MAN, MEDICINE, AND MACHINES"

INCREASING blessings have always brought increasing responsibilities. The present generation has certainly been blessed with a multiplicity of new drugs with almost miraculous efficacy in the treatment of disease. We physicians are so dazzled by the beneficial effect of these drugs that we are apt, oftentimes, to forget the side effects which may seriously affect the patient's judgment and interfere with his reactions. The patient does not know of such side effects unless we tell him, and is even more inclined to disregard them in favor of the beneficial effects obtained. In an age when most men have at least some contact with potential dangerous machinery, such as driving an automobile, piloting a plane, running a train, or operating manufacturing machinery, such disregard of these important side effects of present-day drugs can be disastrous.

A very timely discussion of this problem has been written by Dr. J. R. Winston of Chicago, Ill., and appears in the July 1957, issue of the Santa Fe Magazine. Doctor Winston says in part, "As medicine and machines develop into greater and greater capacities and complexities, so must man's control over them improve. To exercise proper control, man must become increasingly alert . . . he must use good judgment at all times when operating his machine, lest it change from a machine of pleasure and progress to one of pain and destruction." Doctor Winston then points out how a number of factors can influence judgment affecting the operation of such machines, and adds that, "Some of the newer, and some not so new, drugs may under certain circumstances also compromise man's alertness." One is reminded that some of the older drugs, such as opium, morphine and alcohol notoriously affect man's judgment. Among the newer drugs are to be classed the sedatives, the antihistamine drugs, the depressants, the tranquilizers, and drugs used in the treatment of hypertension, etc.

We should not forget to always warn the patient during the use of such drugs and to guard against the development of a serious situation in the operation of machines, which endanger either the patient or other people.

R.L.F.

HOW ASIAN FLU VACCINE WILL BE DIVIDED AMONG STATES

STATE and territories listed alphabetically, and percent of vaccine to each state follows.

Alabama, 1.9; Arizona, 0.6; Arkansas, 1.1; California, 7.9; Colorado, 1.0; Connecticut 1.3; Delaware, 0.2; District of Col. 0.5; Florida, 2.2; Georgia, 2.2; Idaho, 0.4; Illinois, 5.5; Indiana 2.6; Iowa, 1.6; Kansas, 1.2; Kentucky, 1.8; Louisiana, 1.8; Maine, 0.5; Maryland, 1.7; Massachusetts, 2.8; Michigan, 4.4; Minnesota, 1.9; Mississippi, 1.3; Missouri, 2.5; Montana, 0.4; Nebraska, 0.8; Nevada, 0.2; New Hampshire, 0.3; New Jersey, 3.2; New Mexico 0.5; New York, 9.5; North Carolina, 2.6; North Dakota, 0.4; Ohio, 5.3; Oklahoma, 1.3; Oregon, 1.0; Pennsylvania, 6.4; Rhode Island, 0.5; South Carolina, 1.4; South Dakota, 0.4; Tennessee, 2.0; Texas, 5.2; Utah, 0.5; Vermont, 0.2; Virginia, 2.1; Washington, 1.6; West Virginia, 1.2; Wisconsin, 2.2; Wyoming, 0.2; Alaska, 0.1; Hawaii, 0.3; Puerto Rico, 1.3; Virgin Islands, (0.01); Guam, (0.02).

Topics of Current Medical Interest

THE MEDICAL SOCIETY OF THE UNITED STATES AND MEXICO

Arizona Medicine becomes the official organ of the new organization

IT WAS back in 1954 that Drs. H. E. Thompson, W. R. Manning and R. E. Hastings, while in Mazatlan, Sinaloa, Mexico, on the occasion of giving some scientific papers, were asked by local medical leaders to give of their counsel and organizational experience in setting up a Medical Society of Southern Sinaloa.

As a by-product of their successfully completed mission in Mazatlan, the idea of a medical society of the United States and Mexico, germinated. Fertilized by spreading discussion of the subject, increasing support and enthusiasm from colleagues on both sides of the border and a little tincture of time that allowed maturation, the idea was brought to fruition at the first organizational meeting which took place in Tucson, Arizona and which was attended by a Founder's group of both countries. It was called to order on Nov. 24, 1956 at the Pioneer Hotel. Although two scientific papers were presented, the time was spent primarily on organization matters: the basic purpose of the society having been enunciated and agreed upon, committees having been set up to edit a constitution, arrange a program for the next meeting and set up machinery for enrollment and membership.

A much larger group of physicians from Mexico and the United States gathered for the second conclave at the Gandara Hotel in Hermosillo, Sonora, Mexico on March 16, 1957. The constitution and by-laws submitted by the constitution committee were gone over, as well as the table of organization, the bilingual versions being equated. Scientific papers were presented, and a banquet, through the courteous hospitality of the Hon. Alvaro Obregon, governor of Sonora, closed the meeting.

An even better attended session took place in Mazatlan, Sinaloa, in May of this year, where a general assembly approved the constitution and elected officers as follows:

President, Dr. H. E. Thompson, Tucson, Ariz.

President-elect, Dr. H. G. Guevara, Mazatlan, Sin. Mex.

Vice President, Dr. W. R. Manning, Tucson, Ariz.

Secretary for U. S., Dr. J. E. Fonseca, Tucson, Ariz.

Secretary for Mex., Dr. A. L. Guevara, Guadalajara, Jal. Mex.

Treasurer for U. S., Dr. R. E. Hastings, Tucson, Ariz.

Treasurer for Mex., Dr. R. M. Alvarez, Mazatlan, Sin. Mex.

Co-ordinating Committee:

Dr. H. E. Thompson, Dr. H. G. Guevara, Dr. J. Chavez and Dr. W. R. Manning.

The following committees were appointed:

1. Governors' committee — for the purpose of official government liaison and intercession as well as for governmental representation in our society.

2. Educational committee — for promotion of ideas and benefits, particularly at the post-graduate, house officer and fellowship level.

3. Contagious diseases committee — with a mission to deal in epidemiology and international sanitary projects of common interest.

4. Editing committee — assigned the task of clearing, editing and translating the publications of interest to the society or published on behalf thereof.

The following committees were appointed:

EDUCATIONAL COMMITTEE

Chairman: Dr. Ignacio Chavez, Guadalajara, Jal., Mex.; Chairman: Dr. C. Gans, Morenci, Arizona; Dr. A. Topete, Guadalajara, Jal., Mex.; Dr. G. Griffith, Los Angeles, California; Dr. M. Lockie, Buffalo, New York; Dr. L. Dragstedt, Chicago, Illinois; Dr. G. Madrid, Hermosillo, Sonora, Mex.; Dr. J. A. Alvarez, Mexico, D. F.; and Dr. Guillermo Alanilla, Mexico, D. F.

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Jalisco, Mex.; and Dr. Hector Guevara, Mazatlan, Sinola, Mex.

COMMITTEE ON CONTAGIOUS DISEASES

Chairman: Dr. Amado Ruiz Sanchez, Guadalajara, Jalisco, Mex.; Chairman: Dr. M. Carreras, Tucson, Arizona; Dr. Fernando Garcia Robles, Cuilacan, Sin., Mex.; Dr. Luis de Alba Luna, Mazatlan, Sin., Mex.; Dr. Francisco Agraz, Los Mochis, Sin., Mex.; Dr. Carlos Selva, Navajoa, Son., Mex.; Dr. G. Soberanes, Hermosillo, Son., Mex.; Dr. E. Riva Magallon, Magdalena, Son., Mex.; Dr. David Flores Guerra, Nogales, Son., Mex.; Dr. Humberto Rosas, Navajoa, Son., Mex.; Dr. Mario Garcia Montreiul, Baja California, Mex.; Dr. Horatio Quentinella, Mazatlan, Sin., Mex.

Dr. Zenos Noon, Nogales, Arizona; Dr. Calven Williamson, Yuma, Arizona; Dr. L. D. Beck, Phoenix, Arizona; Dr. A. J. DiPinto, Phoenix, Arizona; Dr. H. Ketcherside, Phoenix, Arizona; Dr. Donald Hill, Tucson, Arizona; Dr. W. Fee, Tucson, Arizona; Dr. D. Heim, Tucson, Arizona; Dr. J. Fritz, Tucson, Arizona; Dr. William Wharton, Tucson, Arizona; Dr. Ellis Browning, Springerville, Arizona; Dr. Albert Harris, Globe, Arizona; and Dr. Donald Wilson, Safford, Arizona.

A well represented scientific session was enjoyed by all in which a bilingual presentation of papers made the unanimous appreciation of the material possible.

Plans were then set for the forthcoming meeting, to be held in Tucson, Arizona, at the Santa Rita Hotel on Dec. 5, 6 and 7, 1957.

A complete copy of the program for that session is to be found at the end of this article. Invitations have been sent not only to all practicing physicians in Arizona, Sonora, Sinaloa and Jalisco, but also to a few interested American physicians of both countries as well as to the governors of the four states mentioned, some of whom have honored us with their acceptance.

Invitations for the December meeting in Tucson and reply cards were mailed to all physicians in the State of Arizona, as well as some in other states. They were also sent to all physicians of record in Mexico, in the states of Sonora and Sinaloa. It is expected that, through the Mexican secretary, similar invitations were mailed in the State of Jalisco. All these physicians were also given the opportunity to submit entries for the scientific program. A surprisingly large number of addressees have replied indicating their intention to attend. Those who are working hard to set up a successful meeting are gratified. If any of the readers have not received an invitation and would like to be present, they can fill out and mail the questionnaire to be found at the end of this announcement and mail it at their earliest opportunity. We are happy to announce that the Santa Rita Hotel in Tucson is offering a discount to our Mexican colleagues attending the meeting. Thanks to a comparable generosity on the part of the "Pacifico del Sur" Mexican Railroad, obtained through the good offices of Dr. I. Chavez of Guadalajara, a 50 per cent reduction is being offered in railroad fares to those who attend the meeting.

The Medical Society of United States and Mexico and the editors of Arizona Medicine feel privileged to announce that at a recent meeting of representatives of both, this Journal accepted a request from the society, that this publication become its official organ. The society is grateful and plans to make use of the Journal freely, for announcements, statements of policy, as well as for publication of scientific papers by its members. We all envision a future of co-operative productivity.

It is planned to mail the Journal to the Mexican and other members free of charge. It is also planned to reproduce the material of interest to the society members in both languages.

We look forward to the success of Arizona Medicine's new role in greatly contributing to the realization of the ideals of the Medical Society of the United States and Mexico, especially in facilitating the binational scientific and personal liaison that we all cherish so much.

HEADQUARTERS: Santa Rita Hotel,
Tucson, Arizona – December 5, 6, 7, 1957

Wednesday, Dec. 4

Registration at the Santa Rita Hotel

Thursday, Dec. 5

9 A.M. to 11 A.M.

Committee Meetings

Education Committee

Room – See Lobby Directory

Chairmen: Dr. I. Chavez and Dr. C. Ganz

Governors' Committee

Room – See Lobby Directory

Chairmen: Dr. C. Tapia and Dr. Norman Ross

Editing Committee

Room – See Lobby Directory

Chairmen: Dr. J. J. Vazquez Romo and Dr. M. A. Carreras

Contagious Disease Committee

Room – See Lobby Directory

Chairmen: Dr. Amado R. Sanchez and Dr. M. A. Carreras

11 A.M. – 12:30 P.M.

Executive Committee

Room – See Lobby Directory

President, Dr. H. E. Thompson and President-elect, Dr. H. G. Guevara

12:30 – 2 P.M. – Lunch

Members and wives – (Style Show)

2 P.M. – 5 P.M.

General Assembly

Free Night

Friday, Dec. 6

9 A.M. – 12 Noon

Scientific Assembly

12 – 2 P.M.

Lunch

2 P.M. – 5 P.M.

Scientific Assembly

6:30 – 8 P.M.

Social Hour

8 P.M. – 1 A.M.

Dinner Dance

Saturday, Dec. 7

10 A.M. – 12 Noon

Executive Committee

Davis-Monthan Tour

University Tour

Recreation

Golf

6 P.M.

Social Hour

T.M.C. – 50

Auxiliary Dinner and Show

QUESTIONAIRE

For those who have not already mailed it in.

Dear Dr.

☐ I plan to attend the next meeting of the Society of United States and Mexico in Tucson, Dec. 5, 6 and 7.

☐ I will be accompanied by my wife.

☐ I will not be able to attend.

☐ I am already a paid member.

☐ I am not a member, but would like to join.

☐ I am not on the mailing list of Arizona Medicine, but would like to receive it.

Name .....

Address .....

LA SOCIEDAD MEDICA DE LOS ESTADOS UNITED DE AMERICA Y MEXICO

Arizona Medicine se hace el organo oficial de la nueva Sociedad.

FUE EN el año 1954 que los Doctores H. E. Thompson y W. R. Manning y R. E. Hastings durante su estancia en Sinaloa, Mexico con el motivo de presentar unos escritos cientifcos fueron requeridos por los lideres medicos locales a dar su consejo y experiencia organizacional par desarrolla una Sociedad Médica del Sur de Sinaloa.

Como parte de su éxito en Mazatlan germinó la idea de una Sociedad Medica de los Estados Unidos de America y Mexico. Fertilizada por extensas discusiones sobre la idea, el soporte creciente y entusiasta de colegas de ambos lados de la frontera y un poco de tiempo para madurar, la idea produjo fruto en la primera reunión organizadora que tuvo lugar en Tucson, Arizona y que fué atendida por el Grupo Fundador de ambos paises. La reunión fue llamada a orden en Novienbre 24, 1956 en el Hotel Pioneer. Aunque dos escritos cientificos fueron presentados, el tiempo se uso principalmente en asuntos de organización. Los propositos basicos de la Sociedad fueron enunciados y aprobados, y comités fueron nombrados para escribir una constitución, coordinar el programa para la reunión siguiente y preparar la maquinaria para registros y socios.

Un grupo mucho mayor de Médicos de Estados Unidos y Mexico se reunió para el segundo cónclave en el Hotel Gandara en Hermosillo, Sonora, Mexico en Marzo 16, 1957. La constitución y reglamentos sometidos por el Comité de Constitución fueron examinados asi como la tabla de organización y fueron presentadas en ambos idiomas. Hubieron varias presentaciones cientificas y un banquete, presentado por la cortesia y hospitalidad del Honorable Alvaro Obregón, Gobernador de Sonora, clausuró la reunión.

El primer congreso de la Sociedad, acudido por un gran numero de médicos se celebro en Mazatlán, Sinaloa, en Mayo de este año. La asamblea general aprobó la constitución y eligió los siguientes directivos:

Presidente, Dr. H. E. Thompson, Tucson, Arizona.

Presidente electo, Dr. H. G. Guevara, Mazatlan, Sin., Mex.

Vice Presidente, Dr. W. R. Manning, Tucson, Arizona.

Secretario por los E. U., Dr. J. E. Fonseca, Tucson, Arizona.

Secretario por Mexico, Dr. A. L. Guevara, Guadalajara, Jal., Mex.

Tesorero por los E. U., Dr. R. E. Hastings, Tucson, Arizona.

Tesorero por Mexico, Dr. R. M. Alvarez, Mazatlan, Sin., Mex.

Comite Coordinador:

Dr. H. E. Thompson, Dr. H. G. Guevara, Dr. J. Chavez, and Dr. W. R. Manning.

Los siguientes comités fueron nombrados:

1. Comité de Gobernador — para el proposito de liaison e intercesión oficial de los gobiernos y representación gubernamental en la Sociedad.

2. Comité de Educacion — para la promoción de cambio internacional de ideas sobre educación Médica, particularmente al nivel de post graduado, internos y becarios.

3. Comité de Enfermedades Contagiosas — para interesarse en asuntos de epidemiología y proyectors de salubridad internacional de intereses comunes.

4. Comité Editorial — con la tarea de investigar, editar y traducir las publicaciones de interés a la Sociedad o publicar articulos para la Sociedad.

Los siguientes comites fueron designados:

COMITE DE EDUCACION

Presidente: Dr. Ignacio Chavez, Guadalajara, Jal., Mex.; Presidente: Dr. C. Gans, Morenci, Arizona; Dr. A. Topete, Guadalajara, Jal., Mexico; Dr. G. Griffith, Los Angeles, California; Dr. M. Lockie, Buffalo, New York; Dr. L. Dragstedt, Chicago, Illinois; Dr. G. Madrid, Hermosillo, Sonora, Mexico; Dr. J. Acedo, Hermosillo, Sonora, Mexico; Dr. J. A. Alvarez, Mexico, D. F.; y Dr. Guillermo Alamilla, Mexico, D. F.

COMITE EDITORIAL

Presidente: Dr. M. A. Carreras, Tucson, Arizona; Presidente: Dr. J. J. Vazquez Romo, Hermosillo, Sonora, Mexico; Dr. Hector Guevara, Mazatlan, Sinola, Mexico; Dr. A. Guevara, Mexico, D. F.; Dr. D. W. Neubauer, Tucson, Arizona; y Dr. Juan Fonseca, Tucson, Arizona.

COMITE DE GOBIERNOS

Presidente: Dr. Norman Ross, Phoenix, Arinora, Mexico; Dr. Ignacio Chavez, Guadalajara, Jalisco, Mex.; y Dr. Hector Guevara, Mazatlan, Sinola, Mexico.

COMITE DE ENFERMEDADES CONTAGIOSAS

Presidente: Dr. Amado Ruiz Sanchez, Guadalajara, Jalisco, Mex.; Presidente: Dr. M. Carreras, Tucson, Arizona; Dr. Fernando Garcia Robles, Culiacan, Sin., Mex.; Dr. Luis de Alba Luna, Mochis, Sin., Mex.; Dr. Carlos Selva, Navajoa, Son., Mex.; Dr. G. Soberanes, Hermosillo, Son., Mex.; Dr. E. Rivera Magallon, Magdalena, Son., Mex.; Dr. David Flores Guerra, Nogales, Son., Mex.; Dr. Humberto Rosas, Navajoa, Son., Mex.; Dr. Mario Garcia Montreiul, Baja California, Mex.; Dr. Horatio Quentinella, Mazatlan, Sin., Mex.

Dr. Zenos Noon, Nogales, Arizona; Dr. Calven Williamson, Yuma, Arizona; Dr. L. D. Beck, Phoenix, Arizona; Dr. A. J. DiPinto, Phoenix, Arizona; Dr. H. Ketcherside, Phoenix, Arizona; Dr. Donald Hill, Tucson, Arizona; Dr. W. Fee, Tucson, Arizona; Dr. D. Heim, Tucson, Arizona; Dr. J. Fritz, Tucson, Arizona; Dr. William Wharton, Tucson, Arizona; Dr. Ellis Browning, Springerville, Arizona; Dr. Albert Harris, Globe, Arizona; and Dr. Donald Wilson, Safford, Ari-Arizona; and Dr. Donald Wilson, Safford, Arizona.

Se gozó de una sesión científica bien representada y la presentación bi-lingual hizo posible la apreciación unánime del material presentado. Los planes para la siguiente reunión fueron hechos. Esta reunión se llevara a cabo en Tucson, Arizona en el Hotel Santa Rita en Deciembre 5, 6 y 7 de 1957.

Una copia completa del programa para esta sesión se haya al final de este artículo. Invitaciones han sido enviadas no solo a todos los medicos de Arizona, Sonora, Sinaloa, y Jalisco sino tambien a varios medicos Americanos de otros estados que están interesados asi como a los oficiales de Salubridad Publica de ambos paises y a los gobernadores de los cuatro estados mencionados de los cuales algunos nos han honrado con su aceptación.

Invitaciones y tarjetas de respuesta para la sesión en Diciembre en Tucson han sido mandadas por correo a todos los medicos de Arizona y otros estados y a todos los medicos registrados en los Estados de Sonora y Sinaloa. Esperamos que invitaciones hayan sido tambien transmitidas a los medicos de Jalisco por medio del Secretario por Mexico. A todos estos medicos se les ha ofrecido la oportunidad de someter articulos para el programa cientifico.

Un gran numero ha contestado indicando su

intencíón de atender la reunión. Los socios que están que estón trabajando con entusiasmo para prepara la reunión estan agradecidos. Si alguno de los lectores no ha recibido una invitacion y le agraderia estar presente pueden completar y mandar el cuestionario al final de este escrito.

Nos alegramos en anunciar que el Hotel Santa Rita ofrece un descuento a nuestros colegos de Mexico que vengan a esta sesión y gracias a la generosidad del Ferrocarril "Pacifico del Sur" y al interes del Dr. I. Chavez de Guadalajara un descuento de 50% ha sido ofrecido para el pasaje de los que viajen a Tucson para atender la sesion.

La Sociedad Medica de los Estados Unidos Y Mexico y los Editores de Arizona Medicine se consideran privilegiados al anunciar que en una reciente reunión de representantes de ambas instituciones esta Revista aceptó la petición de la Sociedad que esta publicación sea el organo oficial. La Sociedad esta agradecida y espera usar la Revista frecuentemente para anuncios, declaraciones y publicación de articulos cientificos de sus socios. Todos vislumbramos un gran futuro de productividad mutua.

La revista sera enviada gratis a los socios. Tambien se espera reproducir el material de interes a los miembros de la Sociedad en ambos idiomas.

Todos anticipamos el exito de la nueva participacion de "Arizona Medicine" en la contribución a la realización de los ideales de la Sociedad Medica de Estados Unidos y Mexico, especialmente en facilitar la coalicion binacional cientifica y personal que todos deseamos.

CUARTEL GENERAL: Santa Rita Hotel, Tucson, Arizona – Diciembre 5, 6, 7, 1957

Miercoles, Dic. 4

Registro en el Hotel Santa Rita

Jueves, Dic. 5

9 A.M. – 11 A.M.

Reunión de Comites

Comite de Educacion

Sala – Presidente: Dr. I. Chavez y Dr. C. Gans

Comite de Gobiernos

Sala –

Presidente: Dr. Norman Ross y Dr. C. Tapia

Comite Editorial

Presidente: Dr. M. A. Carreras y J. J. Vazquez Romo

Comite de Enfermedades Contagiosas

Presidente: Dr. Amado Ruiz Sanchez y Dr. M. A. Carreras

11 A.M. – 12:30 P.M.

Comite Ejecutivo

Sala –

12:30 – 2 P.M. Almuerzo

Socios y Esposas (Exhibicion de Modas)

Presentacion de Huespedes Distinguidos

2 P.M. – 5 P.M.

Asamblea General

Noche Libre

Viernes, Dic. 6

9 A.M. – 12 P.M.

Asamblea Cientifica

12 – 2 P.M.

Almuerzo

2 P.M. – 5 P.M.

Asamblea Cientifica

6:30 – 8 P.M.

Hora Social

8 P.M. – 1 A.M.

Comida y Baile

Sabado, Dic. 7

10 A.M. – 12 P.M.

Comite Ejecutive

Paseo por la Base Aerea Davis-Monthan

Paseo por la Universidad

Recreacion

Golf

Paseo por la Universidad

6 P.M.

Hora Social

Comida y Exhibicion por el Departamento Auxiliar del Tucson Medical Center

CUESTIONARIO

Para aquellos quien no lo han enviado.

Dr. Juan E. Fonseca, Secretario
Soc. Med. De E.E.U.U. y Mexico
2409 E. Adams
Tucson, Arizona

Estimado Dr.

☐ Deseo asistir a la proxima reunión de la Soc. Med. de E.E.U.U. y Mex. en Tucson, Ariz. el 5, 6, 7, de Dic. proximo.
☐ Ire acompanado de mi esposa.
☐ No podre asistir.
☐ Ya soy socio.
☐ No soy socio pero deseo inscribirme.
☐ Deseo recibir copia mensual de la revista Arizona Medicine.

Nombre .....

Direccion .....

Ciudad .....

PRINCIPLES OF MEDICAL ETHICS AMERICAN MEDICAL ASSOCIATION

PREAMBLE. These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2. Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3. A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4. The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5. A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6. A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He sohuld neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8. A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9. A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10. The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

DOCTORS ARE CITIZENS, TOO

THESE notes are presented to the members of the medical profession, who wish to participate as responsible citizens in the congressional elections in their own localities, but who are concerned at the efforts of medicine's critics to deny this privilege by designating such acts as "political meddling."

Printed below are simple notes delineating what a doctor may or may not do, under the law, in connection with all federal elections.

LEGAL ASPECTS OF DOCTORS' POLITICAL ACTIVITIES.

1. Legally, it is imperative that doctors who engage in active support of candidates for office do so as individual citizens — and *not* under the auspices of their medical societies.

2. The American Medical Association cannot legally contribute to or expend funds in support of, or in opposition to, candidates for federal office.

3. State and county medical societies, whether incorporated or not, are subject to the *same* limitation.

4. The law prohibits a medical society from:
   a. Endorsing a candidate, where it involves expenditure of general corporate funds,
   b. Contributing funds to any candidate for federal office,
   c. Using medical society letterheads or facilities in advancing work in behalf of a candidate,
   d. Sponsoring any other form of advertising material for a candidate.

5. Individuals forming political committees must not make use of any official position or office which they may hold or occupy in any organization of a medical society nature.

6. These limitations, which appear in the Hatch Act, the Corrupt Practices Act and the new Criminal Code, are sometimes violated by careless or uninformed citizens.

7. American doctors must conduct their political activities *wholly within the law.*

THE POSITIVE SIDE

1. It is the right and duty of every citizen aggressively to further the candidacy of any qualified candidate for federal office and actively to oppose the candidacy of any candidate felt to be unqualified.

2. Any group of citizens, whether on a national, state or county level, can, as individuals, form political action committees for this purpose.

POLITICAL ACTION COMMITTEES

1. Local political committees, operating within a single state, are not required to file detailed reports of expenditures and contributions.

2. A committee operating in two or more states, or as a branch or subsidiary of any national committee, must so file.

WHAT YOU CAN DO AS AN INDIVIDUAL

1. Contribute personally any sum up to a maximum of $5,000 to or on behalf of a candidate for federal office.

2. Solicit and receive contributions for the same purpose, except from those persons who are prohibited from contributing – for example, from persons on relief, or persons holding contracts with the federal government.

3. Actively manage political campaigns or participate in them by writing, speaking or otherwise advocating a candidate's election.

SOME OF THE DOS AND DONTS

1. Anonymous handbills and pamphlets are both illegal and unethical.

The law requires that the name of any person or political committee sponsoring campaign circulars or posters, and the names of responsible officers of any such committee, appear on the printed material.

2. No corporation, whether for profit or not, can make any contribution or expenditure of corporate funds for the purchase of newspaper advertising or radio time in connection with any federal election.

3. Medical societies not only have a right, but an obligation, to participate in registration drives and "Get out the vote" campaigns, where the purpose is to encourage people to exercise their right of franchise, rather than to support any given candidate.

4. A medical society can endorse a candidate editorially in the regularly published periodical of the society, if the cost of publishing the periodical is financed by separate and segregated subscriptions and advertising. Distribution must be confined to subscribers.

5. A medical society can write a letter to any member of congress or any other federal official, commending him on his stand on a medical issue, or it can publish an editorial in its journal or official publication, commending him. But a medical society cannot endorse his candidacy where it involves expenditure of general corporate funds.

6. What are the practicalities of effective doctor-participation of election campaigns?

It is recognized that every doctor should become a crusading citizen at a time when our whole American way of life is threatened.

How can doctors make their influence felt most effectively?

What can they do that will mean votes at the polls on election day?

a. Furnish direction for the profession in your community.

b. Register entire family and vote.

c. Solicit every doctor in your community to spend his full energy to fight in every possible way passage of laws for the socialization of medicine.

7. From experience in many states, a few doctors as citizens can set up a medical-dental committee or a healing arts committee. This type of committee in a congressional election means action on the basis of good citizenship.

8. This committee, in most circumstances, is organized as a branch of the general campaign

committee of a candidate. It takes on the specific job of:

a. Mobilizing all who are affiliated with health activities.

b. Financing its activity through collections from its own group.

9. After the initial organizing committee is established, it normally reaches out for financial support and mass membership through a hard-hitting letter to all members of the profession and allied groups – clearly defining the issue involved and appealing for membership and active participation in the campaign.

10. General meetings are sometimes held to supplement the letter appeal for members.

Give out specific instructions and assign specific duties to the volunteer workers.

11. Decide on a simple plan of campaign which can be interpreted clearly and put into operation with a minimum of time and energy.

12. Without doubt the most effective single mission doctors can perform in a congressional campaign, in most districts, is a thoroughgoing letter-writing job, beamed to his friends and patients – *personal* letters, signed by the doctor on his professional letterhead, and mailed in his own envelopes.

It must be re-emphasized that political action committees of this nature, which lend their support to candidates for federal office, must be independently organized by individual doctors. *They cannot, in any way, be subsidiaries of medical societies, and neither, legally, can the American Medical Association.*

JESSE D. HAMER, M.D.
Chairman – Medical-Legal Committee

J.A.M.A. CLINICAL ABSTRACTS OF DIAGNOSIS AND TREATMENT
edited by **L. Phillips Frohman, M.D.** 564 pages. (1957) Grune & Stratton. $5.50.

From the preface: "From the abstracts appearing in the past year I have selected, for this volume, those which I consider to pertain most directly to the two most important aspects of clinical medicine – diagnosis and treatment. If my efforts have been successful, the result should represent, in one handy volume, the cream of the year's medical literature in a highly condensed form. However, this volume is more than just a collection of selected abstracts, for they have been organized in a manner which was not possible when they were originally published in the Journal." . . . I. Phillips Frohman, M.D.

Stacey's Medical Books, San Francisco.

RX., DX., AND DRS.

By Guillermo Osler, M.D.

THE WESTERN TUBERCULOSIS CONFERENCE was held in Phoenix in September. It gave Arizonans a rare chance to entertain this group, and to hear its non-medical discussions. It elected an Arizona anti-tuberculosis worker to the presidency (Mrs. E. B. Thode). . . . It also presented a brief and neat PROGRAM FOR CHEST SPECIALISTS, and they turned out very well, in conjunction with the Arizona Trudeau Society. Dr. Sanders of Milwaukee, a young but world-known authority, spoke on "dusty diseases." Dr. Roger Mitchell of Denver (and formerly Trudeau San. at Saranac Lake) pondered over what we know, and don't know, about emphysema. Dr. Furcolow of Missouri, entitled to be called "Mr. Histoplasmosis," discussed a movie about his disease and himself. The "mystery cases" of Dr. "Osler" Oatway of California were not much of a puzzle to the Arizona audience — tho they were tough cases. . . . The Western TB Conference is composed of representatives from eight Western states, plus Alaska and Hawaii.

A surgical society with the following partial list of speakers might be considered very fortunate. It included Ochsner of New Orleans, Priestley and Harrington of Mayo's, John Jones of Los Angeles, Puestow of Chicago, Cole of Cleveland, Kaltreider of Baltimore, Harken of Boston, et al. . . . Where would you guess the meeting was held? The OGDEN SURGICAL SOCIETY, OF OGDEN, UTAH. They must have a uranium mine.

We have no conception of the INCIDENCE OF BRONCHITIS in England and Wales. It is said to be 20 to 50 times greater than in Scandinavian countries, for instance. The English blame it on burning coal, with greater air pollution. Infection, and smoking, and the climate are also factors which add to the bronchitic's problem. . . . Kings and commoners alike are affected, tho the opportunity of the poorer groups to escape is less. Actually the chance to minimize the several factors is not very great; what can you do about climate, coal, and even infection? . . . Smoking is a hopeless problem. If a relationship to cancer scares people so that American cigarette sales RISE, what can be done about English bronchitis? You might as well live in Los Angeles!

Two odd "anaesthesias" have recently been described. Both are known better for other purposes. . . . PYRIBENZAMINE solution is used now for topical effect in the bladder, the ears, the esophagus, etc. Did you ever hold a tablet on your tongue while waiting a moment before washing it down? . . . Analgesia is also said to be caused by CHLORPROMAZINE, better known as a tranquilizer, when it is combined with morphine or meperidine.

Abner Fuchs of New York has a few interesting points to make concerning the "COLD-TYPE ILLNESSES". . . . They are caused by a host of viral and bacterial agents. . . . Fifty per cent of those with "cold" symptoms have allergy as a cause (allergic coryza, or allergic rhinitis). They are usually due to airborne substances, with food being an occasional cause. The nasal membranes may be boggy, and they may contain eosinophiles. Antihistamines helps, but are not a substitute for allergic treatment. . . . The APC viruses (adenoid-pharyngeal-conjunctival) have been shown to be caused by at least 17 viral strains. They do not cause the nonfebrile, running-nose type of infection. A vaccine is being tried, but it is of no use in the "common cold." (It is probable that an epidemic in the Tucson schools this spring was due to the APC viruses).

The AVOCATION OF A DOCTOR is often interesting, sometimes startling. An important physician should be most newsworthy. The special interest of the president of the AMA, Dr. David Allman, should be of greatest interest — and is. He has been MEDICAL DIRECTOR OF THE ATLANTIC CITY MISS AMERICA PAGEANT for the past 36 years. . . . Dr. Allman has improved/ spoiled the pageant by changing it from beauty to culture.

A national Sunday newspaper article has made a list of possible MEDICAL "BREAKTHROUGHS" in the next 10 years. This pattern considers the "victories" of the past 10 years, including cortisone, tranquilizers, antibiotics, anti-TB drugs, polio vaccine, etc. It also considers progress and new knowledge on the 10 possible future discoveries. . . . Penicillin reactions should be eliminated in 1957 by a new drug which clears penicillin from the body in a few hours. Blood clots may not only be prevented but dissolved by 1958. Vaccines for viruses which involve the lungs may be available by 1959. A measles vaccine is in sight for 1960. Drugs to alter mental behavior, and allow adaptation to daily stress are on the list for '61. Knowledge about arteriosclerosis may mature by 1962. A better drug for diabetes will be here in 1963. Alcoholism may be better fought by an anti-enzyme in '64. Synthesis of a hormone to stimulate the gonads to production, and to decrease sterility, is possible for 1965. The mystery of schizophrenia may yield to blood analysis by 1966. And by 1967 there may be a chemotherapy for one or more forms of cancer. . . . Anyone want to take a five out of 10 parlay?

The Ayerst Laboratories continue to urge the use of "Premarin," intravenously, FOR BLEEDING of various sorts. . . . They have a "reasonable

interpretation" of the action, with evidence that it leads to a prompt and marked elevation of accelerator globulin (also known as Factor V, proaccelerin, or labile factor), an increase in the level of prothrombin, and a fall in the level of antithrombin. . . . There is no toxicity, it says, and the endocrine function is not disturbed by short-term usage. . . . The drug has been used to "effect hemostasis in well over 400,000 cases," which is more than we've seen lately.

Every now and then A NEW MEDICAL TERM becomes part of the language, sometimes before we know it. If it is specialized or complex, we can only hope that it will be simplified, or go away. If it is chemical or physiologic, as most of them are, we are usually stuck with it. . . . "Properdin" is a system in chemistry which contributes to our immune mechanism. It is called a "natural RESISTANCE TO INFECTION," and was described by Pillemer and associates at Western Reserve in Cleveland in 1954. It was publicly discussed this year at the New York Academy of Sciences. . . . Properdin is effective only when combined with all four components of serum complement, plus magnesium. Properdin levels are low after infection, shock, et al., unrelated to age, sex, etc., but are specific for various animal species, with the highest in the resistant rat, lowest in the susceptible guinea pig, and medium in us humans. It is said to be separate from gamma globulin effect. . . . Don't try too hard to remember details about it, since there are a few skeptics (who probably graduated the same year we did), and quite a lot of work remains to be done on the subject.

. .Here's a report which we'll have to take "on trust." The Squibb Institute for Medical Research says that "Renografin" is a wonderful new contrast medium for INTRAVENOUS UROGRAPHY. . . . They put out a very fine booklet with nine articles by workers from Maryland to Oregon, and from Detroit and New York to Florida. . . . One group said that it had the same efficiency and toxicity as two other media. Others said it was better. . . . Sounds good. Looks good. Maybe so.

MISUSE OF TRANQUILIZER DRUGS is providing as much information as a study of normal dosages. E. C. Hiestand reports on the effects of ingestion (with suicidal intent) of 90 to 95 tablets of meprobromate. She became comatose, and a low BP, fast pulse and rate of breathing. There was no sensory response and muscle tone was absent. Amphetarmine was tried, but stopped, since it affects other CNS areas. An oral airway was established. O2 was given, and mucus aspirated. Phenylephrine was given with 5 per cent dextrose, IV. She began to respond in 18 to 24 hours and was awake and alert at 72 hours. All lab. tests were normal, tho the urine had the fruity odor of meprobromate. Time seemed to have been more effective in this case than drug therapy. . . . Another Ohio clinic (Allen and Black) report the use of Levarterenol and cerebral electrostimulation for ingestion of 32 to 40 tablets of meprobromate. The respiratory and vasomotor collapse seemed notably to be helped by the stimulation, and the patient regained consciousness in 15 hours.

Here comes the attack on NON-FAT DIETS, a counteraction to those who have been urging its use for prevention of arteriosclerosis. . . . Dr. L. J. Baer, a Dearborn heart specialist, told the Michigan Dietetic Ass'n. that the liver and kidneys may be irreparably harmed by the attempts to eliminate unsaturated fatty acids from the diet. . . . Diets should be prescribed by a well-trained physician. They can be cut to a 25 per cent fat content and still be safe, says he.

Constancy in anything could be a major good quality. In writing for publication it certainly is, and even bad but regular columnists have become well known. . . . The Ohio State Medical Journal has a good and constant writer who has specialized in such a way that he is widely read and quoted. Dr. Harry Wein of Mansfield, Ohio, writes a column which consists of about 10 paragraphs. Each one DESCRIBES THE DERIVATION OF A MEDICAL OR PARA-MEDICAL WORD. . . . In a recent series he tells about such words as gene, genetics, genital, giddy, ginglymus, glutens, and gnat. Did you know that "giddy" came from the Anglo-Saxon "gydig" (meaning "God-held, or possessed by gods or demons"), by way of the derivation, "giddian" (meaning "to be merry")?

INJURIES OF THE HAND
by **Ronald Furlong**, F.R.C.S. 215 pages. Illustrated (1957) Little, Brown. $9.

An "instruction manual" deals simply and admirably with common injuries of hand and wrist. Injuries to soft tissue and bone are discussed as to relevant anatomy and techniques. Infections are considered, but therapy in burns and the more elaborate phases of reconstructive surgery are omitted. This should be useful to surgeons who deal infrequently with these problems.

Stacey's Medical Books, San Francisco.

PHS COMMITTEE ADVISES ONE CC SHOT OF ASIAN FLU VACCINE

A public health service advisory committee has recommended that adults be vaccinated with 1 cc of Asian influenza vaccine, but says that two doses of a tenth of a cc each are acceptable for children under the age of five. The children's doses should be given a week apart, injected intracutaneously, PHS says. Recently an American Medical Association committee recommended that "each physician decide for himself" whether to use 1 cc subcutaneously, or one-tenth of a cc intracutaneously for both adults and children.

PHS said its committee made its recommendation after considering both methods. The announcement said:

"The committee considered the question of intracutaneous inoculations of 0.1 cc of vaccine versus the present recommendation of 1.0 cc subcutaneously. It was recognized that information from previous outbreaks concerning the effectiveness of influenza vaccine was obtained from studies in which vaccine was administered subcutaneously, not intracutaneously. However, there was general agreement that influenza antibody levels may be obtained by the intracutaneous route which are comparable with those obtained by subcutaneous inoculation.

"The committee recommended that only the subcutaneous inoculation of 1.0 cc be endorsed for general use in adults. It noted that in certain special instances 0.1 cc given intracutaneously might be used advantageously but physicians using this method must rely on their own judgment regarding its usefulness in each instance.

"The use of two 0.1 cc intracutaneous doses, separated by at least one week in children under the age of five, has been recommended by the American Academy of Pediatrics, was recognized as an acceptable procedure."

With the latest release of Asian influenza vaccine, a total of 13.5 million doses have been made available. Of the latest release, 2,833,856 cc, 2,422,106 cc are going for civilian use and 411,750 for military. The civilian supplies are being distributed to states on the basis of population.

ALLERGIC REACTIONS TO INFLUENZA VIRUS VACCINE*

MONOVALENT influenza virus vaccine, Asian strain, is rapidly being made available in adequate supply. Among the millions of individuals expected to receive this vaccine will be some with varying degrees of sensitivity to the egg protein which is found in this and certain other vaccines prepared from egg-cultured viruses.

It is generally agreed that individuals who in any way indicate that they are allergic to egg-protein should not receive influenza inoculations, since the risk of producing a serious allergic reaction will ordinarily outweigh the risk of serious consequences from an attack of the Asian influenza, which so far has been a relatively mild and self-limited disease in the United States.

The American Foundation for Allergic Diseases is aware that it is common practice for the physician to ask his patient if he has any allergy or sensitivity to egg protein before such vaccines are given. Each vial of the new influenza vaccine contains a reminder on this point. However, because inoculations will be given in great numbers and possibly by nurses and technicians, the foundation is underscoring caution as regards the individual allergic to egg protein. The mass vaccination aspect increases the chance that patients with definite egg-protein sensitivity may present themselves for vaccination, unaware of this allergy, or careless in communicating to the physician that they have previously experienced sensitivity to eggs.

Allergic reactions due to egg hypersensitivity may occur following the injection of virus vaccines in persons of any age, but they are more common and apt to be more severe in young children. The injection of egg protein as a diagnostic procedure in very sensitive children has resulted in severe anaphylactic shock.

Ratner and Untracht found that one out of five allergic children exhibit dermal sensitivity to egg protein and this sensitivity is of clinical significance in about one out of 20 such allergic children. Practical clinical experience indicates

*Statement to physicians on allergic reactions to Asiatic Influenza vaccine by the American Foundation for Allergic Diseases.

that allergic reactions to virus will be encountered in fewer than one out of every several hundred persons receiving the vaccine, when, as is anticipated with the influenza vaccine, millions are inoculated. The majority of egg-protein allergies will be mild. Dangerous reactions are extremely rare.

Much of the difficulty will be avoided as the physician exercises caution in determining egg-sensitivity. Where there is doubt, or the physician feels it is important to establish that tolerance exists, the patient may be given an intradermal test with the vaccine itself. This should be performed with a 1:10 dilution, since undiluted vaccine produces a mild local reaction in nearly everyone. If a systemic or a severe local reaction occurs in response to the intradermal test, sensitivity is indicated and the vaccine should not be given. The test itself should, of course, be administered with caution.

A burning sensation at the site of injection and a mild febrile reaction may occur in some individuals receiving the vaccine and should not by themselves, be misinterpreted as signs of an allergic response.

Physicians administering the vaccine will customarily have antidotes for allergic reactions conveniently at hand, and patients suspected of sensitivity may be observed in the office or clinic for half an hour after injection. The physician may wish to prescribe a tablet or capsule of a potent antihistaminic which the patient may take if a delayed reaction should occur.

OCT. 1, 1957 PROGRESS REPORT OF THE POISON CONTROL INFORMATION CENTER AT THE UNIVERSITY OF ARIZONA COLLEGE OF PHARMACY

SINCE the Sept. 1 report, 27 poisoning cases have been received at the poison control center. The statistics of the reports in rounded figures are as follows:

Age:

85 per cent involved the age group of 5 and under

15 per cent involved the age group of 16 to 30

Time:

37 per cent occurred between 6 a.m. and noon

37 per cent occurred between noon and 6 p.m.

18 per cent occurred between 6 p.m. and midnight

4 per cent occurred between midnight and 6 a.m.

4 per cent were unknown

Nature of incident:

96 per cent were accidental

4 per cent were intentional

Outcome:

100 per cent recovery

Causative agents:

30 per cent aspirin

30 per cent insecticides

7 per cent pain relieving preparations.

33 per cent miscellaneous, including window cleaner, stain remover, laxatives, plastic cement, pleasant pills, laundry bleach, a combination of sleeping pills and tranquilizers, lamp black, and sleeping capsules.

FEDERAL MEDICAL LEGISLATION

THIS is an interim report on health and medical legislation in the 85th congress. It summarizes all action taken on health measures up to the time of adjournment on Aug. 30, and lists all significant bills that will be awaiting decision in the second session starting Jan. 7, 1958.

The small number of health-medical bills enacted this year might be regarded as deceptive. Actually 441 of these bills were introduced – a record total even for a first session. Congress deferred action on most of them for a variety of reasons – a desire for more extensive hearings, economy, and, possibly, an inclination to save some popular-appeal bills for next year. Experience has shown that the second session, always an election year, is the crucial one, when forces line up for final decisions on the big, controversial medical bills.

For example, no action was taken this year on such important measures as U. S. aid to medical schools and health insurance for federal civilian workers, nor on a growing list of ideas for government-paid hospitalization of OASI beneficiaries, a proposal that would have an obvious impact on the practice of medicine. There is every reason to believe congress won't neglect these subjects next year.

HEALTH LEGISLATION ENACTED

Doctor draft extension (*PL.* 85-62) – Because the doctor draft was set to expire July 1, this was one of the first health measures passed by the 85th congress. It gives selective service authority until July 1, 1959 (when both this amendment and the regular draft expire) to call certain physicians up to age 35 for military service. Only those under age 35 with obligations under the regular draft and who have been deferred for any reason may be called. Defense department, meanwhile, says it is getting enough medical school graduates as reservists to preclude use of the new law at this time.

Medical research (*PL* 85-67) – Another early enactment was the fiscal 1958 budget for the department of health, education, and welfare. Congress voted $2,503,130,381 for all HEW programs, including record high totals for medical research through the National Institutes of Health. Congress can – and in all likelihood will – receive requests from the administration for additional money during the current fiscal year – through a deficiency appropriation.

Vendor medical payments (*PL* 85-110) – This law is intended to resolve some problems arising out of the social security amendments of 1956 with particular reference to vendor medical payments for public assistance recipients. Under PL 110, states are given the choice of either (a) using federal funds for vendor medical payments within the $60 a month per recipient maximum or (b) establishing a single medical vendor payment financed by federal funds which were set by a 1956 law at one-half of $6 a month per adult and one-half of $3 per child, to be matched by states. States also can continue to make direct payments to recipients for medical and subsistence expenses.

Disability freeze extension (*PL* 85-109) – Under this law, a new deadline of July 1, 1958 is established for disabled persons covered under social security to apply for full retroactivity under the disability freeze passed in 1954. Applications filed by next July will allow workers to count the full period of disability provided they were eligible for disability benefits at the time the disability was incurred. After next July 1, any period of disability established for a worker cannot begin earlier than one year before the application is filed.

Indian & non-Indian hospitals (*PL* 85-151) – At the urging of some Western members of congress, PL 151 was enacted to authorize federal funds to help build non-profit or public hospitals and diagnostic or treatment centers on or near Indian reservations; the extent of federal contribution will be determined by the percentage of care given eligible Indians. The facilities have to agree to care for both Indians and non-Indians.

Vocational rehab traineeships (*PL* 85-198) – This measure extends from two to three years the maximum period of time over which the federal government can pay for partial financing of traineeships in physical medicine and rehabilitation. It amends the Vocational Rehabilitation Act which was expanded in the 84th congress.

Vocational rehab planning (*PL* 85-213) – amends the Vocational Rehab Act by extending the time federal funds may be used for planning, preparing and initiating expansion of programs in the states. Congress was asked to

act when the July 1 deadline approached with considerable unexpended funds on hand.

Codification veterans laws (*PL* 85-56) – Without making any substantative changes in existing law, this congress brought into a single code all veterans benefit laws, including those providing for hospital and medical care. Some of the laws date back 30 years.

Poultry inspection (*PL* 85-172) – under this law, federal inspection of poultry moved in interstate commerce becomes compulsory.

Military nurses incentives (*PL* 85-155) – In line with earlier efforts to make careers in the military more attractive. Congress passed this law improving career prospects for military nurses by making more and higher ranks available.

BILLS THAT PASSED ONE BRANCH OF CONGRESS

Pulmonary tuberculosis (*HR* 1264) – The bill declaring veterans suffering from active pulmonary tuberculosis to be permanently and totally disabled for pension purposes while hospitalized passed the house, but is pending in the senate finance committee.

HEARINGS HELD BUT NO FURTHER ACTION TAKEN

Bricker amendment (*SJ Res.* 3) – The longstanding proposed amendment to the Constitution by Senator Bricker (R., Ohio) limiting the domestic effect of treaties and other international agreements.

Civil aviation medicine (*S* 1045) – Would establish in the Civil Aeronautics Administration an office of civil aviation medicine along with a medical research institute.

Welfare-pension plans registration (*S* 1122, *S* 2888) – Provide for registration, reporting and disclosure of employee welfare and pension benefit plans. Both house and senate committee hearings held and some action expected next session.

Highway safety (*S* 1292) – Hearings in house but not on any specific bills. Proposals include compulsory installation of safety belts.

OVR pilot center (*S* 2068) – Would give the office of vocational rehabilitation authority to use federal funds for construction of facilities for a pilot rehab center in the Washington area.

Non-service-connected care (*HR* 58) – Would impose added requirements on veterans with non-service-connected disabilities seeking hospitalization or domiciliary care in VA facilities.

Barbiturates control (*HR* 503 & *others*) – Regulate the manufacture, distribution and possession of habit-forming barbiturate and amphetamine drugs, and provides for registration and record-keeping, but with doctors exempted.

Department of civil defense (*HR* 2125 & *others*) – Establish a new executive department of civil defense which would have supremacy over the military in times of disaster in certain defense areas.

Salary rise for VA doctors (*HD* 6819) – Increases salaries of medical personnel in VA, and also raises optometrists to the level of physicians for purposes of pay.

Chemical additives (*HD* 6747 & *others*) – Require pre-testing of many chemical additives to be used in food processing and marketing. The house has held extensive hearings on this subject.

Grants-in-aid-study (*H. Res.* 312) – Provides for a select committee of the house to study federal grants-in-aid to state and local governments, and other groups. It got as far as house rules committee approval.

Advisory group for blind (*HR* 8427) – Establishes a temporary national advisory committee for the blind.

BILLS STILL IN COMMITTEE; NO HEARINGS HELD

Hospitalization for aged (*HR* 9467, 9448 & *others*) – Various bills provide through different approaches a certain number of days of free hospitalization each year for old age and survivors insurance recipients and beneficiaries, some bills also would pay in-hospital surgical and medical care costs.

Compulsory health insurance (*S.* 844, *HR* 3764) – A 1957 version of the old and rejected national compulsory health insurance measures of 1948, the sponsors being Senator Murray (D., Mont.) and Rep. John Dingell, Jr. (D., Mich.)

Liberalizing OASI coverage (*S.* 173 & *others*) – These measures would liberalize the age and coverage requirements in the OASI disability program.

OASI coverage for doctors (*HR* 8883) – Phy-

sicians would be brought under social security on a compulsory basis.

Jenkins-Keogh plan (*HR 9 and 10*) — Defer federal income taxes on portions of earnings of the self-employed for the purchase of retirement plans.

OASI tax increase (*HR 7669*) — Increases the wage base from the present $4,200 to $6,000 in computing the OASI tax.

Federal workers' health insurance (S. 2339 & *others*) — Provide for a voluntary, contributory health insurance program for federal employees and their dependents, both basic and major medical coverage.

Overseas federal medical care (*HR 6141*) — Provides health and medical services for U. S. civilians overseas who are employed in government jobs, and also would cover their dependents.

Federal medical school aid (*HR 6874*) — Authorizes federal grants to medical schools and research facilities for construction of classrooms and laboratories for teaching.

National radiation institute (S. 1228 & *H.R.* 4820) — Establish a national radiation health institute within the National Institutes of Health.

Lobbying amendments (S. 2191) — Would rewrite regulations covering lobbyists and lobbying in congress.

Federal loans to hospitals (*HR 1979*) — For those hospitals interested in construction loans rather than Hill-Burton grants, these bills would authorize long-term government loans.

Reinsurance (S 1750 & *HR 6506*) — Permit pooling by various insurance companies without regard to the anti-trust laws for purpose of encouraging new experiments in health insurance coverage.

Aid for the aged (*HR 383 and others*) — Authorize grants for studies and projects for the aged.

Federal advisory health council (*HR 2435 and others*) — Establish a federal advisory council on health, as recommended by the Hoover commission.

Longshoremen's Act (*HR 7303* & S. 2400) — Amend the Longshoremen's and Harbor Workers Compensation Act so that injured workers can select their own physician and hospital.

Labeling for household use (*HR 7388 and others*) — Regulate the labeling of hazardous substances intended for household use.

FOLSOM HEALTH AIDE LISTS MEDICAL NEEDS, CITES PROBLEMS OF AGED

SECRETARY Folsom's special assistant for health and medical affairs, Dr. Aims C. McGuinness, has outlined some major health items which may serve as the framework of the administration's health goals for the 1958 session of congress. In an address in Maine at the dedication of a new chronic disease and rehabilitation facility, Dr. McGuinness made these points:

Health aid to the elderly — The principles of voluntary insurance should be applied to the prepayment of medical expenses of a higher proportion of elderly people; the administration feels voluntary health insurance can advance this goal most effectively. PHS also plans to develop demonstrations of home-care services, health maintenance clinics and restorative services. (Several bills now in congress would offer hospitalization to OASI beneficiaries.)

Hospital care costs — Physicians must constantly ask themselves if they are putting a patient in a hospital when he could be served as well or better on an ambulatory basis. It is essential the problem of rising hospital care costs be solved.

Rural health — In the more rural areas where hospital facilities might not be available at all, the most essential health services could be provided through diagnostic and treatment centers. (Several proposals have been made for Hill-Burton-type grants for clinics separate from hospitals. Under present law diagnostic and treatment centers must be owned by a state, political subdivision or public agency, or by a corporation or association that owns and operates a nonprofit hospital.)

Hospital role in medicine — General hospitals must broaden their services and achieve greater co-ordination. The term "hospital care" should include not only bed care, but diagnostic service and service to ambulatory patients as well.

Federal medical school aid — Failure to help meet the needs of medical schools would be the worst kind of false economy. The administration's pending $225 million program of construction grants would bring classrooms and laboratories much closer to current and projected needs.

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—with a much higher degree of safety

—even when therapy is maintained for long periods

—at significant economy for the patient

Each tablet of Pabalate-HC contains 2.5 mg. of hydrocortisone—50% more potent than cortisone, yet not more toxic.

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In each tablet:

Hydrocortisone (alcohol)	2.5 mg.
Potassium salicylate	0.3 Gm.
Potassium para-aminobenzoate	0.3 Gm.
Ascorbic acid	50.0 mg.

DOSAGE: Two tablets four times daily. Additional information on request.

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VETERANS ADMINISTRATOR SCORES DOCTORS ON MEDICAL CARE ATTITUDE

VETERANS Administrator Harvey Higley has told the American Legion that some medical men now apparently believe that the public is no longer greatly concerned with the veteran and his problems. "And so they no longer hesitate to attack medical care for veterans, with particular reference to those having non-service-connected disabilities." Ten years ago, "there were few who would challenge the legislation, in effect since 1924, which provides that a veteran with a service-connected disability has the right to enter a VA hospital if he cannot pay for the care elsewhere and if the VA has a bed available," he told the Legion convention in Atlantic City.

His solution: a firm legislative policy on VA hospitalization, something he said he has been seeking for many months. Commented Mr. Higley: "So long as a definite policy is lacking, requests for new and additional beds will receive little if any consideration." He then reiterated his plan for settling on a level of 125,000 authorized beds in VA hospitals.

Mr. Higley said that if the policy is to rule out care of non-service-connected cases, this should be frankly stated so that states, counties and cities may take up the load.

He placed the number of non-service-connected veterans on the waiting list at 22,000 of whom 17,000 are suffering from mental illness. He proposed the closing down of 3,906 unneeded tuberculosis beds and their replacement with 3,300 other beds. New construction would include a 1,000-bed hospital in Gainesville, Fla., which Mr. Higley said he was confident could be staffed "contrary to our situation elsewhere." Other hospital needs: 250-bed addition to hospitals at Coral Gables and Bay Pines, Fla.; a new 300-bed unit in southern Texas, and 500-bed addition in southern California. These last three would be general medical and surgical beds.

Because nearly 5,000 of the mentally ill veterans are in the New York City area, a 500-bed addition at Montrose, N. Y., would be needed at a minimum, according to Mr. Higley.

PULMONARY COMPLICATIONS OF ABDOMINAL SURGERY by A. R. Anscombe, F.R.C.S. 121 pages. (1957) Year Book. $4.

The many facets of a problem that still plagues even the most skilled and conscientious abdominal surgeons are presented concisely and comprehensively. Physiological principles, etiology, and management are emphasized.

Stacey's Medical Books, San Francisco.

Organization Page

CIVICS

By Norman A. Ross, M.D.

A careful review of the following Articles of Incorporation of the Arizona Medical Educational Foundation is presented. These articles were not written by a physician. The following then, shows the public's opinion and the interest and the responsibilities they assign to members of their medical profession. I offer this as typical of today's medical public relations in Arizona.

ARTICLES OF INCORPORATION OF ARIZONA MEDICAL EDUCATIONAL FOUNDATION

Know All Men By These Presents:

THAT we, the undersigned, all residents of the State of Arizona, and citizens of the United States, having voluntarily associated ourselves together for the purpose of forming a nonprofit corporation pursuant to the provisions of Sections 10-451, et seq., Arizona Revised Statutes, adopt the following articles of incorporation for such corporation:

ARTICLE I

The name of the corporation shall be *ARIZONA MEDICAL EDUCATIONAL FOUNDATION.*

ARTICLE II

The principal office for the transaction of the business of the corporation shall be in Phoenix, Arizona, but this corporation may do and transact business and its Board of Directors may meet at such other place or places or in any other jurisdiction of the United States of America or elsewhere in the world as may be convenient or necessary for the conduct of the business of the corporation.

ARTICLE III

This corporation is organized, not for profit, and its objects and purposes to be carried on are to receive and maintain funds and apply the income and principal thereof to promote the well-being of mankind throughout the world. It shall be within the purposes of said corporation to use, as means to that end, research, publication, the establishment and maintenance of charitable, benevolent and medical research activities, agencies and institutions and the aid of any such activities, agencies, institutions and colleges already established and any other means, persons or agencies which from time to time shall seem expedient to its membership or directors and which shall further the purposes above named, and to build and promote a hospital or hospitals, medical school or college or colleges as it deems necessary to further its purposes, and to buy, sell, lease, sublease and market such real property and personal property as this corporation might adequately and reasonably need, and to conduct all other activities incidental to the purposes of this corporation.

In addition to the foregoing, and in furtherance and not in limitation of the powers conferred by the laws of the State of Arizona and the objects and purposes herein set forth, this corporation shall have the following powers:

(a) To encourage medical research, tests and other phases of medical work, and the training, as well as the education, of persons in the several fields of health, including by illustration, hospital administrators, nurses, technicians, vocationally trained persons, public health personnel and health educators;

(b) To encourage the preparation of original papers on medical topics;

(c) To publish papers and reports and disseminate knowledge and experience of value to the practice of medicine;

(d) To co-operate with educational institutions in the maintenance of high standards of medical education;

(e) To encourage the personal and professional development of young doctors.

* * *

From the American Medical Association Washington Letter, Oct. 4, 1957, we offer their report of a statement by Basil O'Connor, president of the National Health Council, definitive of the new commission on health careers of this association. Mr. O'Connor is also the head of

the National Foundation for Infantile Paralysis.

The new commission will "plan ways to meet the acute need for qualified health personnel in the United States."

According to Mr. O'Connor, lack of manpower "poses the biggest threat not only to our present health services, but to the future progress of medical science. . . . Many people, when they think of the health professions, naturally picture the physician, the dentist and the nurse. Actually the range is infinitely broader. Workers in more than 150 health occupations guard the well-being of American citizens. Many of these professions are inter-linked and mutually dependent. The great majority are dangerously understaffed."

• • •

The Arizona Medical Educational Foundation in its broad approach to health education was formed in recognition of Arizona's need, and to promote and co-ordinate these 150 separate health educational activities.

AMERICAN CANCER SOCIETY

REGION Six of the American Cancer Society held its Annual meeting Sept. 23 and 24, 1957 with the prime topic of discussion, the Application of Cytology in the Detection of Uterine Cancer. The faculty included Dr. Ian McDonald of the University of Southern California, Dr. David A. Wood of the University of California, Dr. E. G. Holmstrum, of the University of Utah, and Dr. Harris Barber of Albuquerque, N. M.

In the establishment and implementation of the cytology program on the local level, the cancer society is to be commended that it is taking a cautious approach and will take every step that is practical and feasible to co-ordinate the program with the state and local cancer societies and have the doctors who must carry out this program fully aware of the plan under consideration.

The Arizona Division is establishing a cytology co-ordination committee to fit the program to the needs of this division. A full understanding will be obtained with the pathologists of the state and no steps taken without their full cooperation. If a plan is accepted, it will be submitted to the council of the Arizona Medical Association for its endorsement. Then an effort will be made to recruit and train such screeners as may be necessary to aid the pathologists. It is contemplated that not more than 3.3 per cent of all slides that are screened should necessitate review by the pathologist in control of the program.

The Arizona Division feels that it is in a position to assist in the establishment or aid in the establishment of facilities, should such steps become necessary.

Through the local units of the cancer society, a professional educational program will be organized for the dissemination of information as applicable to this program to the community doctor.

The above professional education program in turn will be followed by a public education program to acquaint the public with the established program and the facilities available.

In every case, strict efforts will be made to maintain a normal patient-doctor relationship and an effort pursued to continue this program on an annual basis in a self-supporting manner.

If the cancer society can follow these steps as laid out by the national organization, it is likely that we can probably save an additional 16,000 women each year from death by cancer of the cervix. For certainly with carcinoma in situ developing approximately 10 years prior to invasive cancer, we should be able to take adequate steps to prevent the invasive disease from developing.

MENTAL DEPRESSIONS AND THEIR TREATMENT
by Samuel Henry Kraines, M.D. 55 pages. (1957) Macmillan. $8.

The problem of depressions, one of the most mishandled and misdiagnosed medical disorders, is covered probably more comprehensively than in any prior book. This one will give any physician the armamentarium with which to meet the gamut of depressions, from routine problems to the major psychotic difficulties.

Stacey's Medical Books, San Francisco.

OBESITY: Its Cause, Classification, and Care
by E. Philip Gelvin, M.D., and Thomas H. McGavack, M.D. 146 pages. (1957) Hoeber-Harper. $3.50.

The authors state in the preface, "We have no panacea to offer, nothing sensational nor magical. We do feel that the program for the management of obesity as presented in these pages is safe, effective, and consistent with principles of good nutrition, yet simple for the physician to prescribe and convenient for the patient to observe."

Stacey's Medical Books, San Francisco.

HEALTH INSURANCE

THE number of persons protected against the cost of hospital and surgical care through insurance company policies has been increasing at an accelerated pace in recent years, reported the Health Insurance Institute. In an analysis of the trends in voluntary health insurance coverage in the United States during the past six years, the institute said that the growth rate in the last three years of both forms of health cost coverage has risen markedly with each succeeding year.

According to figures supplied by the nation's insurance companies, the institute's analysis revealed, there were 66.3 million persons covered for hospital expenses at the end of 1956 through individual and family health policies and through group insurance programs, a 79 per cent increase over the 1950 total of 37 million.

A closer examination of this growth trend over the past three years shows a constantly faster rate of expansion in hospital expense protection. In 1954 there was an increase of 5.9 per cent over 1953 in the number of people covered, the percentage gain in 1955 over 1954 was 7.9 per cent, and the rate of growth in 1956 over 1955 was 11.1 per cent.

Surgical expense insurance, which helps pay for the cost of operations, included some 63 million persons covered in 1956, through policies available from insurance companies the institute report said. Compared with the 1950 total of 33 million, the rate of growth in the number of people protected was 91 per cent during this six-year period.

As with hospital expense insurance, the yearly increase in the number of people with insurance policies covering surgical expenses has been accelerating during the past three years, the institute pointed out. The rate of growth in 1954 was 4.6 per cent over 1953; in 1955 the increase was 7.3 per cent over 1954; and 1956 recorded a rise of 11.2 per cent in the number of people protected over the comparable period for 1955.

Regular medical expense insurance experienced a phenomenal period of expansion in the six years covered by the institute study. A relatively newer form of health cost protection as compared with hospital and surgical expense insurance, regular medical expense coverage, providing for doctor visits for non-surgical care, rose 281 per cent in the number of people covered between 1950 and 1956. By the end of last year, there were 29.8 million persons included in policies available from insurance companies covering costs for medical care, as compared with 7.8 million in 1950.

Comparing the growth trends of regular medical expense insurance during the past three years, the institute reported a 12.9 per cent increase in 1954 over 1953, and a rate of growth of 20.8 per cent between 1954 and 1955. In 1956 the increase in the number of people was 18.9 per cent over 1955.

The newest form of health cost protection, major medical insurance, outpaced all other forms of coverage. Introduced by the insurance business in 1948, major medical expense policies help cover the costs of serious, or catastrophic illness, including hospital bills, physi-

ANALYSIS OF GROWTH OF VOLUNTARY HEALTH INSURANCE 1950-1956*

Type of Coverage	1950	1951	1952	1953	1954	1955	1956
HOSPITAL EXPENSE:							
No. of persons (000)	36,973	44,572	47,272	52,218	55,282	59,654	66,259
Yearly per cent increase		20.6	6.1	10.5	5.9	7.9	11.1
Net persons gained (000)		7,599	2,700	4,946	3,064	4,372	6,605
SURGICAL EXPENSE:							
No. of persons (000)	32,994	40,013	45,328	50,464	52,806	56,645	62,996
Yearly per cent increase		21.3	13.3	11.3	4.6	7.3	11.2
Net persons gained (000)		7,019	5,315	5,136	2,342	3,839	6,351
MEDICAL EXPENSE:							
No. of persons (000)	7,807	11,430	14,265	18,361	20,721	25,031	29,756
Yearly per cent increase		46.3	24.8	28.7	12.9	20.8	18.9
Net persons gained (000)		3,623	2,835	4,096	2,360	4,310	4,725
MAJOR MEDICAL EXPENSE:							
No. of persons (000)			689	1,220	2,198	5,241	8,876
Yearly per cent increase				77.0	80.2	138.4	69.4
Net persons gained (000)				531	978	3,043	3,635

*Adjusted for duplication of persons covered among insurers.

cians' charges and other medical care services, and are available alone or as a supplement to the other types of expense policies.

At the end of 1952, when the first accurate records were available, there were some 689,000 persons in the nation with major medical coverage. In the four years since, this form of health insurance rose at an unprecedented rate of 1,188 per cent, for a total in 1956 of 8.9 million persons. A recent estimate made by the Health Insurance Council was that, as of May 1, 1957, this total exceeded 10 million persons, demonstrating a continuance in the rapid growth of this form of insurance against the cost of illness and accident.

A breakdown of the analysis of the six-year trend in voluntary health insurance coverage is shown in article.

SOCIAL INSECURITY

L. D. Sprague, M.D.

THIS year, the first time, the social security system will *pay out more* money than it collects in payroll taxes. This fact has already received some notice in the press, but has been reviewed with too little critical analysis. Payroll taxes fell short by $125 million of covering the benefits paid out to the social security recipients during the fiscal year just ended. Social security planners themselves predict a deficit of roughly $300 million for this year, and they say it may run as high as $1 billion for the next year!

Physicians have, fortunately, thus far escaped from being entrapped in this form of welfareism. However, as certainly as night follows day, tremendous pressures will be brought to bear during the coming session of congress to bring physicians under compulsory inclusion in the system. Even a minority of physicians themselves are looking with some favor upon inclusion. Such groups are particularly vocal in the East and include the Physicians' Forum of New York. This leftist group, it might be well to recall, testified in congress in the 1940s for passage of the Murray-Wagner-Dingel socialistic government-controlled medical care bills so vigorously opposed by organized medicine. The American Medical Association has consistently voiced its opposition to compulsory inclusion of physicians under the Social Security Act. Attention should be drawn to the word "compulsory" and fair warning given that congress will never authorize a voluntary type of coverage for physicians, as advocated by some. The reasoning behind the AMA's opposition is based on sound practical and philosophical principles.

A progressive increase in the tax levy has been and will continue to be a feature of the system. By 1960, under present planning, payroll taxes will advance for all persons under the Social Security Act. Workers and employers will pay, each, 2¾ per cent; self-employed persons will then pay 4⅛ per cent, based on income of $4,200 per year. The tax rate and the tax base have progressively increased since 1935 from 1 per cent on $3,000 to present rates. A continued progressive increase in both tax rate and tax base are built-in features of the system. No one has any idea how much social security is going to cost next year or even 20 years from now. Congress may at its discretion raise the taxable base to any figure and will be forced to raise both the base and rate to prevent eventual bankruptcy of the system. At what point this generation, or the next, will awaken and rebel and refuse to pay unfair, increasingly heavier taxes to cover the cost of relief payments for their parents, is anyone's guess.

We are told by the chief actuary of the social security system that the deficit will be made up in 1960 by these increases in the tax rate and by "trust fund" investment income. There exists a great deal of misunderstanding, due principally to the misrepresentations of the social security administration's propaganda, concerning the so-called "trust fund." The administration has misled the people into believing that their tax payments are held in a separate "trust fund" to guarantee "benefit" payments. This is an out-and-out falsehood. The administration's latest figures (May 1957) show the unfunded obligation of social security to be approximately $300 billion, (this is in addition to the figure of $270 billion national indebtedness). These obligations do not include the added costs of the increased benefits likely to be enacted in 1958. The "trust fund" is composed mostly of IOUs in the form of bonds, and little actual cash. The compulsory collected taxes have not been deposited in the fund, but have been spent for other services of government, such as foreign aid, relief programs, etc. Once collected, they

are transferred to the general fund and IOUs substituted for cash, for the most part, in the "trust fund." Such IOUs constitute a debt of government (you and I). The only way the government can pay this debt, since it has no income except that which it takes from its people in the form of taxes, is by collecting more taxes from its citizens, most of whom have already been taxed once for the social security IOUs. The "trust fund" is then nothing more than a lien against future taxes. The social security system must, at best, become more burdensome taxwise and the so-called income from investment which the planners tell us will wipe out the deficit by 1960 is nothing more than more of the government's power to tax.

This also serves to explain why the social planners are so anxious to "provide" for doctors and their families under the provisions of the Social Security Act. As shown, deficits must be made up out of increased taxes. To further delay the ultimate financial bankruptcy of the system as it stands today, more higher income bracket producers must be brought into the system whose higher taxes will reinforce it and conceal the true state of affairs for the time being. Physicians comprise the ideal group for this purpose. Almost all would pay maximum tax levies and very few would ever reap any return on their money. Eighty-five per cent of physicians between the ages of 65 and 72 are continuing in active, private practice, and thus would not be eligible for "benefits." A typical physician would be required to pay maximum social security taxes until age 72 without receiving any benefits. Social security retirement benefits are not of significant value or concern to the self-employed physician. Any survivorship benefits which might accrue to widows of physicians upon their death prior to age 72, we are reliably informed, can be purchased on a more practical and economical basis from private insurance companies.

Based on the amendments of 1954, for each 50 cents paid in taxes to social security, $30 will be paid out in benefits. We, therefore, are mortgaging future generations to pay for a welfare state of this generation's concoction. A few examples will clarify more forcefully what the disparity in amounts paid in taxes versus benefits paid out really means. Let us reduce this to terms of a single individual whom we will assume started at age 21, in 1937 (when social security deductions first went into effect) and was making the maximum taxable salary. At age 65, after having paid maximum taxes for 44 years, a total of $4,221 will have been deducted from his salary and a like amount contributed by his employer for a total of $8,422. If he and his wife live out their life expectancy, they will collect a total of $22,494 in benefits. The difference of $14,052 must be made up by other taxpayers, present or future. It is difficult to obtain reliable figures on social security statistics even from the Bureau of Old-Age and Survivors Insurance, Department of Health, Education and Welfare. Figures varying from $6.2 billion paid in and $5.7 billion paid out to $5.7 billion paid in and $5 billion paid out are quoted from the year 1956. Figures from $55,600,000 to 69 million persons covered for the year 1956 have been given. Being conservative and lowering the $14,052 deficit of the above illustration to $10,000 and using the lower figure of 55,600,000 persons covered, present liability under the social security system *alone* (not including the national debt) amounts to $556 billion — more than *twice* the estimated total wealth of the entire nation. This liability is not a static one, but is growing by leaps and bounds every day. However generous its motives, such a federal pension fund cannot go on forever incurring obligations which exceed its resources. We sincerely believe that most physicians will resist inclusion in such a scheme because it is presently unsound and can only lead to national bankruptcy; because it is creating an enormous debt to be paid by future generations, your children and grandchildren; and because we have no moral right to place such an obligation upon future generations.

Millions of small businesses and professional self-employed, ranging from doctors, lawyers, and accountants to salesmen and undertakers, have an opportunity to provide for themselves retirement income on a sensible, sound, basis during the year 1957-1958. It appears now that it is not so much of a question of whether the principle of tax deferment for the self-employed will be enacted during the next congressional session, as to what extent congress will limit the amount of savings the self-employed will be allowed to set aside (tax deferred) for old age. Tax deferment for the salf employed as embodied in the Keogh legislation deserves the enthusiastic and whole-hearted support of every

physician. Inclusion under the social security system should be fought vigorously and an educational campaign launched to acquaint doctors and the public with the dire consequences of continuance of the program as it is now constituted.

REFERENCES:
1. Social Security, Fact and Fancy, (Dillard Stocks), Henry Regnery Co., 1956.
2. Time, Aug. 26, 1956.
3. Dan Smoot Report, April 29, 1957; July 8, 1957.
4. JAMA, Vol. 164, No. 16, Aug. 10, 1957.
5. JAMA, Vol. 162, No. 3, Sept. 15, 1956.
6. JAMA, Vol. 162, No. 4, Sept. 22, 1956.
7. JAMA, Vol. 164 No. 18, Aug. 31, 1957.
8. Medical Economics, Aug., 1957.

LOCATION OPPORTUNITIES

(Released October 4, 1957)

ASHFORK – Pop. 700 – North centrally located – Railroad center – Contact the Women's Club, Ashfork, Ariz.

BENSON – Excellent opportunity for GP – This David-Benson trade area has about 5,000 population with only one doctor available. A small sleep-in hospital can be set up very easily. Hospital 25 miles away. Chamber of commerce will furnish telephone answering service, nine to five. Contact Bernard Fisher, D.D.S., Medical committee of the chamber of commerce, Benson, Ariz.

CAMP VERDE – Located in the heart of a large farming and ranching area on the Verde River. Approximately 100 miles north of Phoenix. Badly in need of a medical doctor. Contact Ivy N. Moser, R. N., Camp Verde, Ariz.

FLAGSTAFF – Pop. 17,500 – Largest city in the north central Arizona trading area. One pediatrician is needed (as there are a number of general practitioners who would gladly refer work to him). Excellent opportunity for an EENT doctor and a general practitioner. Contact C. Herbert Fredell, M.D., Secretary, Coconino County Medical Society, 121 East Aspen Ave., Flagstaff, Ariz.

GILA BEND – Pop. 2,500 – 80 miles west of Phoenix – Nearest town to the Painted Rock Dam Project – Good opportunity for general practitioner. Cattle, cotton and general farming. Office and equipment available. $150 monthly income from board of supervisors. Contact Mrs. J. F. Allison, Box 485, Gila Bend, Ariz.

HAYDEN – Pop. 4,000 – Located in southern Arizona. Need for a general practitioner. Have only one doctor available now. Mostly industrial area. Swimming pool, golf course, theater and social clubs. Has a local clinic, with Ray Hospital 24 miles away. Contact Charles B. Huestis, M.D., Box 928, Hayden, Ariz.

MIAMI – Opportunity for GP – Industrial hospital staffed by approximately seven doctors, who care for personnel and families of those who work for the three principal mining companies. This community is served by numerous small mining and ranching interests. Contact Robert V. Horan, M.D., Miami-Inspiration Hospital, Miami, Ariz.

MORENCI – Mining community located near New Mexico-Arizona border – Pop. 10,000 – Has vacancy at hospital for GP. Contact Carl H. Gans, M.D., Morenci Hospital, Morenci, Ariz.

PHOENIX – Good opportunity for associate radiologist in Phoenix area. Contact Ernest Price, M.D., 9112 No. 2nd Street, Phoenix, Ariz. (WI 3-3491).

SAFFORD – In need of GP – Pop. 6,000 – Has ideal year-around climate with good schools, park, swimming pool, golf course, Elks Club. Private hospital, open staff. Surgical privileges after six months if qualified. Completely equipped office for rent and equipment for sale. Contact M. T. Sandeno, M.D., 803 – 7th St., Safford, Ariz.

SAN MANUEL – Completely new mining community, just a nice drive from Tucson, Ariz. Urgently needs a physician to be associated with the copper mining company located there. Contact Francis M. Findlay, M.D., San Manuel Hospital, San Manuel, Ariz.

SHOW LOW – Pop. 1,500 – Trading center for some 10,000 people. Summer and winter recreation area, cool climate and beautiful forest country. At present there is no M.D. in Show Low and it wishes to locate a doctor there who would help establish a hospital. The town is anxious to locate a doctor and promises full cooperation. Contact either Mary and Eric Marks, Paint Pony Lodge, Show Low, Ariz., or Donald F. DeMarse, M.D., Box 397, Holbrook, Ariz.

TOLLESON – In need of GP – Serves a trading population of from 12,000 to 15,000. Ten miles west of Phoenix. Elementary and high schools, churches of all denominations. Complete office and equipment for GP available on reasonable term lease or purchase. Contact Mr. Norman Andersen, president, chamber of commerce, 9112 West Van Buren St., Tolleson, Ariz.

TUCSON — The VA Hospital is in urgent need of an orthopedic surgeon. They prefer someone who is board certified, but would take someone who has had special training, as they have the local men in this field available for consultation service. State license is necessary but not necessarily an Arizona license. Contact S. Netzer, M.D., Director, Professional Service, VA Hospital, Tucson, Ariz.

YOUNGTOWN — Pop. 130 — Located 16 miles from Phoenix and just a few miles from several small towns, each a potential field of practice. Most residents are 60 years of age or older and are in need of medical care. Office space is currently provided at no rental. A medical center is being planned. Interested doctors may contact Mr. Sid Lambert, Box 61, Marionette, Ariz.

FOR INFORMATION ON OPPORTUNITIES IN THE FIELD OF INDUSTRIAL MEDICINE, CONTACT:

Harold J. Mills, M.D., Phelps Dodge Hospital, Ajo, Ariz.

Carl H. Gans, M.D., Phelps Dodge Hospital, Morenci, Ariz.

Ira E. Harris, M.D., Miami-Inspiration Hospital, Miami, Ariz.

Charles B. Huestis, M.D., Box 928, Hayden, Ariz.

Elvie B. Jolley, M.D., Copper Queen Hospital, Bisbee, Ariz.

H. W. Finke, M.D., Magma Copper Company Hospital, Superior, Ariz.

John Edmonds, M.D., Kennecott Copper Corporation Hospital, Ray, Ariz.

Francis M. Findlay, M.D., San Manuel Hospital, San Manuel, Ariz.

LOCATION INQURIES RECEIVED DURING MONTH OF SEPTEMBER 1957

(Released October 4, 1957)

CALLAN, JOSEPH A., M.D., 98 Vermilion Drive, Virginia, Minn., *I*, age 28, married; 1954 graduate University of Minnesota; interned at Hurley Hospital, Flint, Mich. Wishes to locate in a town of 5,000 to 25,000 population. Interested in specialty practice or a general practice. Will also consider industrial practice. Available in three months.

DeGEORGE, FRANK, M.D., 287 Tremont St., Syracuse, N. Y., *Pd*, Age 30; 1955 graduate University of Tennessee; rotating internship at New York State Medical Center and affiliated hospitals, Syracuse. Will complete residency in pediatrics in June 1958. World War II veteran. Will consider any type of practice.

DEVENIS, ALGIRDAS M., M.D., 115 Vine St., Hartford, Conn. *Ob-Gyn*, age 32; 1953 graduate New York Medical College; rotating internship at Kings County Hospital; will complete Ob-Gyn residency at Hartford Hospital, Hartford, Conn., in July 1958. Interested in specialty work with clinic or associate type practice.

DOWLEN, JOSEPH A., M.D., 3040 Nevada, Minneapolis 36, Minn., *S*, age 38; 1944 graduate Southwestern Medical College; interned at Denver General Hospital and will complete residency at Minneapolis General Hospital in January 1958. Interested in assistant, associate or solo practice.

FINDLAY, PRENTISS E., M.D., Charity Hospital, New Orleans 12, *Pd*, age 28; 1954 graduate Emory University; presently in residency at Charity Hospital. Prefers practice in his specialty. Available July 1958.

FRIEDMAN, HERBERT S., M.D., 4504A Bonner Road, Baltimore, Md., *U*, age 29; 1952 graduate University of Illinois. Will complete residency in July 1958. Prefers assistant or associate practice.

LEHMAN, THEODORE H., M.D., University of Oregon Hospitals, Portland, Ore., *U*, age 31; 1953 graduate University of Nebraska. Now completing a 4-year residency. Prefers specialty in clinic or with associate. Available July 1958.

McCOWN, LOUIS K., M.D., 1516 - 3rd Ave. N.E., Rochester, Minn., *I*, age 33, married; 1949 graduate Tulane; internship at University of Wisconsin Hospitals; presently in residency at Mayo Clinic; interested in clinical, assistant or associate practice; available Jan. 1, 1958.

SCHULDES, RUDOLPH E., M.D., St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown 4, Ohio, *Ob-Gyn*, age 35; 1951 graduate University of Basel; is now completing 3 years residency. Prefers clinical or associate practice. Available July 1958.

SOSHEA, JOHN W., M.D., 1015 Madison, Evanston, Ill., *I* and *Rheu*, age 32; 1949 grad-

uate Northwestern; has had 3 years training and 2½ years practice time in internal medicine; interested in group practice; available now.

HIRD, WAYNE E., M.D., McGuire VA Hospital, Richmond, Va., *TS* and *CS*, married; 1950 graduate Kansas University. Qualified general surgery – taking boards this year. Will be qualified in TS and CS in July 1958. Wishes to practice only TS and CS in association with one or more private clinics.

COMMITTEE APPOINTED TO STUDY MEDICAL RESEARCH, EDUCATION

SECRETARY Folsom has named a special committee of medical leaders and industrialists to advise him on the "status and future needs" of medical research and education. He asked the members to study such questions as:

1. Impact of expanding research programs on medical education.

2. Availability of scientists, technicians, and facilities.

3. Relative emphasis given to research in the various disease fields.

4. Relative emphasis given to fundamental studies in the basic sciences generally.

5. Relationship between federal and private research programs.

6. Standards for approval of research projects.

Chairman of the committee is Dr. Stanhope Bayne-Jones, former Yale Medical School dean and more recently president of the New York Hospital-Cornell Medical Center joint administration board and head of medical research and development for the army.

Other members are: Dr. George Packer Berry, dean, Medical School, Harvard University; Thomas P. Carney, vice president, Eli Lilly and Company, Indianapolis; Dr. Lowell T. Coggeshall, dean, division of biological sciences, University of Chicago and formerly special assistant to the HEW secretary; Fred Carrington Cole, vice president, Tulane University, New Orleans; Samuel Lenher, vice president, E. I. duPont de Nemours and Company, Wilmington; Dr. Irvine H. Page, director of research, Cleveland Clinic Foundation; Robert C. Swain, vice president in charge of research and development, American Cyanamid Company, New York; Dr. Stafford L. Warren, dean, School of Medicine, University of California Medical Center, Los Angeles, James Edwin Webb, president and general manager, Republic Supply Co., Oklahoma City, former undersecretary of state and former director of the bureau of the budget.

In announcing the committee, Secretary Folsom said:

"The medical research programs of this department and of the nation generally have expanded very rapidly over the past decade and have contributed substantially to advances in the health of the American people.

"We are deeply interested that our medical research efforts continue to make a maximum contribution based on wise policies and sound administration. In view of the increasing magnitude of the total medical research effort and how much is at stake in its progress or shortcomings, I have decided to appoint several distinguished consultants to review not only the department's activities in these fields, but the situation in medical research and medical education in the country as a whole."

COLOR ATLAS OF DERMATOLOGY, Vol. 4
by P. De Graciansky, M.D. and S. Boulle, M.D. Illustrated. Yearbook. Sold only by the set, $140.

This is the fourth and final volume in this superb contribution to medical literature. The 320 full-color plates, with 320 pages of detailed legends, are presented 80 plates to each volume. The binding is loose-leaf. The legends appear facing the plates they describe. Translated and adapted from the original French edition, they include in exact detail every pertinent fact of the most minute clinical feature of the pathology illustrated. Because only a limited quantity of the color plates could be imported, the number of sets (and it can be sold only as a 4-volume set) of this Atlas is greatly limited.

Stacey's Medical Books, San Francisco.

HOW TO SAVE FEDERAL INCOMES TAXES THROUGH THE USE OF A SIMPLE REVERSIONARY TRUST*

LeRoy B. Evans
President, Dow Theory Forecasts, Inc.
Hammond, Ind.

ONE of the doctor's most pressing financial problems today is his high federal income tax.

He would like to reduce it without reducing his earnings . . . and while this seems like "pie-in-the-sky," it can be done through the use of a simple reversionary trust with the income payable to and taxable to the beneficiary.

For years, trusts have been widely used for tax and other purposes; the reversionary trust is relatively new, however, and trusts that transfer the tax liability to the beneficiary are downright rare.

The reversionary trust differs from the standard trust in that the corpus (body) of the trust reverts back to the donor after a period that cannot be less than 10 years.

This enables an individual who does not need the income from certain investments to divert that income to a beneficiary for a period not less than 10 years, and, after that time, receive back his original investment.

Then, if the trust is properly drawn, the beneficiary is also made responsible for the tax which can mean the difference between a minimum 20 pr cent tax which the trust would ordinarily pay, and no tax at all because of the beneficiary's normal tax exemption.

Thus, the simple reversionary trust becomes one of the most effective legitimate opportunities for a doctor temporarily to shift to others some of his investment income, and, more important, also the tax burden that goes with it.

Ideal for Parents

This simple reversionary trust is ideal for parents with young children who will later go to college and for those with dependents with little or no income of their own.

For example, on an investment yielding $500 annually, a doctor in the 50 per cent bracket would have to pay $250 tax . . . but his son or daughter would not have to pay any tax at all if they received the $500 and didn't have too much other income.

Since any taxpayer can have taxable income up to $675 without having to pay any federal income tax, and because $50 of the dividend income would be non-taxable, the annual dividend income to the beneficiary could be up to $725 per year, reduced by income from other sources, if any, without his having to pay any federal income tax.

If the beneficiary is your child under 19 (or a child in school, regardless of age) and you furnish over half of that child's support, you would not lose the dependency exemption for that child because of the trust income. However, if the beneficiary is an adult dependent other than the above, then it is recommended that the beneficiary's gross income from all sources be less than $600 per year to prevent loss of dependency exemption.

Here is a table showing how much more you would have to invest or how many times the rate of return you would need to accomplish results equal to this trust. (See page 705)

What to Use as Corpus of Trust

Practically anything can be used as the corpus or body of a reversionary trust. A mutual fund is very suitable as it provides a broad investment program in one security under the supervision and management of professional analysts; it is simple to use in a trust and since most funds are composed largely of common stocks, it also provides a hedge against inflation.

The value and dividends on the shares will increase or decrease with changes in market value and income of the investments in the fund, of course, but the management has the responsibility of managing the fund to meet the changing conditions, to the best of its ability.

This is very important since a reversionary trust must run a period not less than 10 years.

How Much to put in Trust

A trust can be written with a corpus of any amount from $1 to $1 million, or more. It all depends on how much income is to be diverted to the beneficiary. However, there is usually a minimum charge made for the administrative work of the trust officer, (usually $25 or $50 an-

*Reproduced by permission.

nually depending on locality and the policy of the bank) and therefore trusts of at least $5,000 would seem advisable.

But whatever amount is used, the donor should proceed with care as any investment that results in lower taxes is usually carefully scrutinized by the internal revenue department; this is especially true of a trust such as discussed here which makes the income taxable to the beneficiary and not to the trust.

The simple reversionary trust holds important opportunities for tax savings but all benefits can be thrown away by a wrong sentence, phrase, or even a single inadvisable word in the trust instrument. This is truly a time when the phrase "investigate – then invest" is appropriate.

The least that any doctor wishing to consider such a trust should do is write us for further information before proceeding. There is no charge for this service.

If your tax bracket is	Amount you would need to earn to clear $600 after federal income taxes	Without this trust, you would have to invest the following number of times as much money (at any given rate of return) to clear the same amount (up to $600 per year).	If you have a specified amount to invest, without this trust, you would have to earn the following number of times the rate of return to the trust to clear the same amount (up to $600).
30 per cent	$ 857.14	1.42	1.42
40 per cent	1,000	1.66	1.66
50 per cent	1,200	2.0	2.0
60 per cent	1,500	2.5	2.5
70 per cent	2,000	3.33	3.33
80 per cent	3,000	5.0	5.0

WHAT DO YOU MEAN — "NON-PROFIT"?

ONE of the chief distinctions between medically sponsored prepayment plans – such as Blue Shield – and the commercial health and accident insurance companies, is that Blue Shield is conducted on a "non-profit" basis, whereas the insurance companies are frankly business enterprises operated to earn a profit for their owners.

To state this difference is not to imply any criticism of either. The insurance companies have a long and honorable history of public service and they are an important part of America's business community.

Blue Shield, on the other hand, *serves largely as an agency of the medical profession, performing a community service.* Initiated by the medical profession, with the help of local industry, labor and civic leaders, Blue Shield is designed for one purpose only: to help people pay for medical services whenever the need for such services arises.

Blue Shield has succeeded in pioneering the medical care prepayment movement because the profession has guided it and supported it. Blue Shield's working capital was the pledge of the participating physician to deliver the medical services that Blue Shield has promised on his behalf.

In some cases, the participating physicians have accepted a fraction of scheduled Blue Shield payments in order to tide an infant plan over its early trials. In every case, local professional leaders have given their local Blue Shield Plans incalculable hours of service as trustees and advisers. None has ever accepted one penny of compensation for such service as a committee member or trustee. As an agency of the medical profession, created for the sole purpose of facilitating the doctor's job of service to his patients, there has never been any need (for a third party) to make a profit out of the Blue Shield transaction.

Blue Shield's success is measured by the proportion of its income dollar that is expended for services to subscribers, the smallness of its operating costs and the quality of its doctor-support – *not* by the size of its reserves or its net earnings.

These earnings – these profits, if you will – belong to the subscriber.

"Non-profit" does not mean *no* profit. Much less does "non-profit" mean a profit-less operation. "Non-profit" in Blue Shield means that the earnings of the Plan belong to the subscribers who support the Plan.

Obituary

DR. DAVID ENGLE

DR. DAVID EDWIN ENGLE of Tucson died of a coronary occlusion, Sept. 28, 1957 at St. Mary's Hospital. Dr. Engle, 48 years of age, was born in Frankfort, Ind. He graduated from DePauw University in 1930 and received his M.D. degree at Indiana University in 1934. His internship and residency in medicine were spent at Indianapolis General Hospital in 1934-36. This was followed by a Master of Science in Medicine at Mayo Foundation Division of the University of Minnesota in 1939. He remained as first assistant on the staff of the Mayo Clinic until he entered private practice in Illinois in 1940 while instructing at the University of Illinois School of Medicine. From 1942-45 he saw active service in the Army of the U.S.A. as head of the department of cardiovascular disease for the General Base Hospital No. 32 in the ETO.

Dr. Engle came to Tucson in 1947 where he has practiced internal medicine with cardiology as his specialty. His offices were located in Medical Square. He was a Diplomate of the American Board of Internal Medicine, and a Fellow of the American College of Physicians. He was also a member of the American Medical Association, Arizona Medical Association, Pima County Medical Society, American Heart Association, Arizona Heart Association (president 1954-55), American Society of Internal Medicine, Arizona Society of Internal Medicine, Medical Society of United States and Mexico, and served as a director and vice-president of Arizona Blue Shield.

Dr. Engle was an active staff member of the three Tucson hospitals, having served as chief of staff at Pima General, as chief of medicine and as a member of the medical board of directors of Tucson Medical Center, and as chief of medical services and member of the governing staff of St. Mary's Hospital.

Dr. Engle was an elder in the Trinity Presbyterian Church, a member of Delta Upsilon, Nu Sigma Nu.

Dr. Engle is survived by his wife, Faith, of Tucson and a daughter, Suzanne, who is a sophomore at Colorado College, Colorado Springs, Colo.

Dr. Engle brought to Arizona medicine, in its stage of rapid expansion following World War II, excellent judgment and good treatment. We regret his loss.

Obituary

DR. JAMES KELVIN HAZEL

Dr. Hazel was born in Marysville, Mont. June 24, 1895. He received a Bachelor of Science degree from the University of Michigan in 1917, and a Master of Science degree from the same university, during the course of his studies for the medical degree which was received in 1925. He interned at the Fresno County General Hospital from 1925-26 and married Lenore Winterfield the following year. He worked for a time for the United Verde Copper Co. at Jerome, Ariz., and was affiliated with the Industrial Surgery Associated Indemnity Corp., San Francisco, Calif., for a time. Most of his private practice was performed around the Bay area. He was at San Mateo for 25 years. He served as orthopedic surgeon with overseas duty in both World War I and World War II.

His last three years he served as staff physician for the Kennecott Copper Company at Hayden, Ariz. His professional affiliations included membership in the American Medical Association, the California State Medical Association, The Arizona Medical Association, and the Gila County Medical Society.

He was a member of the American Legion and the BPOE.

He was the father of six children. He died of coronary thrombosis on April 21, 1957, at Hayden, Ariz.

H.R.

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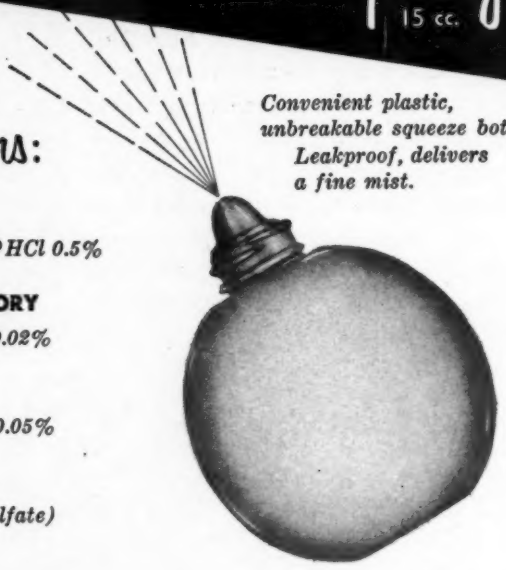

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Future Meetings

NOTICE

HE Medical Society of the United States and Mexico will hold its next meeting at the Pioneer Hotel, Tucson, Ariz., Dec. 5, 6, and 7, 1957. We strongly encourage your attendance at this meeting.

AMERICAN CANCER SOCIETY SEMINAR

Jan. 23 through 25, 1958
Tucson Inn
Tucson, Ariz.

PANEL

Axel N. Arneson, M.D., Onconological Gynecologist, 457 North Kings Highway, St. Louis 8, Mo.

James Barrett Brown, M.D., Plastic Surgeon, 508 North Grand Avenue, St. Louis 3, Mo.

Vincent F. Collins, M.D., Therapeutic Radiologist, Baylor University, College of Medicine, Houston, Texas.

Ross Golden, M.D., Diagnostic Radiologist, University of California, Medical Center, Los Angeles 24, Calif.

Cornelius F. Lehmann, M.D., Dermatologist, 705 East Houston Street, San Antonio, Texas.

Ian G. MacDonald, M.D., Oncological Surgeon, 2009 Wilshire Boulevard, Los Angeles 57. Calif.

Arthur Purdy Stout, M.D., Pathologist, Columbia University, College of Physicians and Surgeons, 630 West 188th Street, New York 12, N. Y.

E. Dale Trout, Ph.D., Physicist, General Electric Company, 4855 Electric Avenue, Milwaukee 1, Wis.

Thursday, Jan. 23 – 9:45 through 11:30 a.m.
SKIN TUMORS – Doctors Brown, Collins and Lehmann

1. Loctor Lehmann: "Diagnosis of Skin Cancer" 25 minutes. (Dr. Lehmann will please submit a list of lesions he would like to discuss)
2. Doctor Collins: "Radiotherapy of Skin Lesions" – 25 minutes.
3. Doctor Brown: "Surgical Treatment of Skin Lesions" – 25 minutes.

12-2 – Luncheon with round table discussion. (cost included in registration fee)

Thursday, Jan. 23 – 2:30 through 4:00 p.m.
CANCER OF THE HEAD AND NECK – Doctors Brown, Collins, Golden, MacDonald and Stout.

1. Doctor Golden: "Roentgen Diagnosis of Diseases of the Sinuses and Larynx" – 15 minutes.
2. Doctor Stout: "Carcinoma in situ (Larynx)" – 20 minutes.
3. Doctor Brown: "Surgical Treatment of Cancer of the Head and Neck" – 20 minutes.
4. Doctor MacDonald: "Prophylactic Neck Dissection, Prophylactic Neck Irradiation. Surgery vs. Irradiation, Carcinoma of the Lip and Larynx" – 20 minutes.
5. Doctor Collins: "Radiotherapy in Cancer of the Head and Neck" – 15 minutes.

Friday, Jan. 24 – 9:30 to 11:00 a.m.
THE ABDOMINAL MASS – Doctors Golden, MacDonald and Stout.

1. Doctor Golden: "Diagnostic Procedures and Examples in Differential Diagnosis of Abdominal Masses" – 30 minutes.
2. Doctor Stout: "Pathology of Abdominal Masses" – 30 minutes.
3. Doctor MacDonald: "Surgery of Abdominal Masses, Including a Discussion of the Curability of Late Cancer" – 30 minutes.
4. Doctor Collins: "Radiotherapy of the Abdominal Mass" – 30 minutes.

Friday, Jan. 24 – 2:30 to 4:00 p.m.
PELVIC TUMORS – Doctors Arneson, Collins and Stout.

1. Doctor Arneson: "The Pros and Cons of Endometrial Carcinoma" (Surgery alone, irradiation alone, combined therapy) – 30 minutes.
2. Doctor Collins: "Cancer of the Ovary" – Therapy – ?Cobalt – 30 minutes.

12-2 – Luncheon with round table discussion.
Saturday, Jan. 25 – 9:30 through 10:15 a.m.
Mr. Trout: "The Application, Limitation and Dangers of Radiation Therapy" with some discussion of proper equipment, proper application, and in view of the recent publicity, some discussion, if possible, of radioactive fallout.
10:30 a.m. through 12
END RESULTS AND COMPLICATIONS –

Doctors Arneson, Brown, Collins, MacDonald and Stout.

1. Doctor Brown: "The Treatment of Lesions from Irradiation, Atomic Radiation and Cathode Ray Burns" – 15 minutes.
2. Doctor Arneson: "Carcinoma of the Cervix following Cervical Irradiation, End Results" – 15 minutes.
3. Doctor MacDonald: "End Results, 600 Cases of Carcinoma of the Breast" – 15 minutes.
4. Doctor Stout: "Results Following 2 M.E.V. Irradiation in Inoperable Lung Cancer" – 15 minutes.
5. Doctor Collins: "End Results and Complications Cancer of the Breast" – 15 minutes.

The American Academy of General Practice has approved the American Cancer Society seminar to be held at the Tucson Inn, Jan. 23-25, 1958, for a total of seven hours formal credit (Category I).

THE PREMATURE BABY
by V. Mary Crosse, M.D. 4th ed. 181 pages. Illustrated. (1957) Little, Brown. $5.

Complete information is given about premature infants: characteristics, management, care (both institutional and home), clothing, feeding, and complications.

Stacey's Medical Books, San Francisco.

PROGRESS IN GYNECOLOGY, Vol. 3
edited by Joe V. Meigs, M.D., and Somers H. Sturgis, M.D. 779 pages. Illustrated. (1957) Grune & Stratton. $15.50.

Advances in the field since the publication of volume two in 1950 are recorded under the term "progress." Contributions of outstanding authorities provide current concepts under one cover.

Stacey's Medical Books, San Francisco.

Phoenix Clinical Club

The Case History in this discussion is selected from the Case Records of the Massachusetts General Hospital, and reprinted from the New England Journal of Medicine. The discussant under Differential Diagnosis is a member of the staff of the Massachusetts General Hospital. The other discussants are members of the Phoenix Clinical Club.

MASSACHUSETTS GENERAL HOSPITAL

PRESENTATION OF CASE NO. 41472

A 52-year-old man entered the hospital because of hoarseness.

The patient was in excellent health until three months before admission, when he began to feel "run down," weak and anorectic. Over the next two and a half months he lost approximately 10 pounds of weight. One month before entry he noticed the onset of a hacking cough productive of small amounts of nonbloody sputum. This was followed by the gradual appearance of hoarseness, which progressively increased up to the time of admission. An examination of the larynx done in the clinic revealed paralysis and fixation of the left vocal cord. A lateral x-ray film of the neck was normal. The patient was referred to the hospital for further study.

The past history was noncontributory. There was no difficulty in swallowing and no dyspnea, hemoptysis or pain in the chest. The patient had smoked one or two packages of cigarets every day for many years.

Physical examination revealed a well developed man with evidence of recent weight loss. The voice was hoarse and rasping. The neck was normal, the chest was resonant, with a harsh late inspiratory wheeze in the right side. The heart was normal, as was the abdomen. There was marked clubbing of the fingers and toenails and no cyanosis.

The temperature was 97°F., the pulse 76, and the respirations 18. The blood pressure was 160 systolic, 85 diastolic.

Urinalysis was negative. Examination of the blood revealed a hemoglobin of 12.2 gm. per 100 cc. and a white-cell count of 8,400. A blood Hinton test was negative. The albumin and globulin were normal, and liver functions tests were negative. An electrocardiogram was within normal limits.

An x-ray film of the chest showed a round mass protruding into the left-lung field just below the aortic arch. The mass appeared to lie in the anterior mediastinum and showed slight pulsations. The lungs were emphysematous, with depression and flattening of the diaphragm. The leaves of the diaphragm moved equally bilaterally. The anteroposterior diameter of the chest was increased. There was no mediastinal shift. The heart showed prominence of the left ventricle and the aortic arch. Fluoroscopy of the chest with multiple views of the lung fields showed no other masses. The mass previously described moved with the aortic arch in a manner suggesting that it was fixed to it. An angiocardiogram revealed that the mass stated to be in the region of the left ductus node did not opacify as the dye went through the pulmonary vascular circuit and the aorta. The left-upper-lobe pulmonary artery was pressed upon by the mass, and there appeared to be some irregularity of the left upper posterior apical pulmonary artery, suggesting the possibility of attachment to the vessel wall. In the later films there appeared to be a compression upon the left lateral inferior aspect of the aortic arch by the mass.

Bronchoscopy revealed paralysis of the left vocal cord and questionable slight deviation of the trachea to the right. The right and left main bronchi and their lobar branches appeared normal. Bronchoscopic washings from the left main bronchus were negative for tumor cells.

On the 13th hospital day an operation was performed.

DR. JOHN A. EISENBEISS

The present case concerns a 52-year-old Caucasian male who entered the hospital because of hoarseness and was in excellent health until three months prior to admission, when he began to feel run down and weak. Additional compliants were cough of a hacking nature, without production of bloody sputum, present one month, weight loss of 10 pounds in the past 2½ months, and hoarseness which had been present one month and was progressive in nature. The pertinent physical findings were paralysis of the left vocal cords, a hoarse, rasping voice, and

inspiratory wheeze in the right chest, clubbed fingers and toes, normal heart, a blood pressure of 160/85.

Laboratory studies revealed a normal white count and hemoglobin, serology, liver function tests and electrocardiogram. X-rays revealed a round mass below the aortic arch, anterior-mediastinum, which pulsated somewhat. The heart was prominent, left ventricular shadow. Mass moved with aortic pulsation. Angiogram revealed no dye in the mass, however the left pulmonary artery was pressed upon by the mass. There was irregularity of the left upper posterior apical pulmonary artery, with compression of the left lateral inferior aspect of the aortic arch. There was some question of attachment of the mass to the aorta and irregularity of the upper posterior apical pulmonary artery, and questionable attachment to this vessel wall. Bronchoscopy corroborated the paralysis of the left vocal cord and there was a questionable deviation of the trachea to the right. Bronchial washings revealed no evidence of tumor cells.

The only neurologic sign is hoarseness with paralysis of the left vocal cord. This implies a lesion of the vagus nerve below its exit from the jugular foramen and at the origin of its recurrent laryngeal branch on the left side. Of interest is the course of the recurrent laryngeal nerve in that on the left it arises at the left of the arch of the aorta at the point where the ligamentum arteriosum is attached. This is a remnant of the obliterated ductus arteriosus.

The causes of recurrent laryngeal paralysis, statistically, in some 61 cases revealed that 28 of these were incident to aneurism in the arch of the aorta; four to mitral stenosis; six to enlarged bronchial and other adjacent glands, none incident to apical lung lesions; eight incident to malignant diseases of the lung; five new growths in the thorax; eight malignant disease of the esophagus; two thyroid tumors. Of 360 cases of recurrent laryngeal paralysis, 103 were toxic or infectious, 63 traumatic, including surgical trauma, 40 aneurisms of the arch of the aorta, 27 neoplasms, 12 tuberculosis, 10 goiter, 10 enlarged left auricle, four enlarged glands, 64 central causes, 27 other causes.

The mass as localized by my interpretation of the anatomical notes by x-ray and angiography, is that it is not of primary pulmonary origin, and is benign in view of the negative bronchoscopic findings and washings. If tumor had been present, and a tumor of a malignant nautre, temperature elevation, white count elevation, would very likely have been present.

Of further import is the presence of clubbing of the fingers and toes of marked degree, without cyanosis. This suggests pulmonary circulatory disease of some duration. Specifically, the recurrent laryngeal paralysis occurs as noted previously in aortic arch disease, 5 per cent; in malignant disease, 12 per cent; in new growths in the lung, 8 per cent; in enlarged bronchial and other glands, 10 per cent; in mitral stenosis, 6 per cent. Apical lung disease, esophogeal, and thyroid disease can be excluded on the basis of the findings, symptoms, and examination.

Therefore, my diagnosis is aneurism of the arch of the aorta. Very likely, this aneurysm originated in or near the ligamentum arteriosum, or in a partially patent ductus arteriosus, with thrombosis formation accounting for the failure of filling on angiography; or my secondary impression, dermoid or thymoma.

DIFFERENTIAL DIAGNOSIS

DR. HELEN S. PITTMAN: The differential diagnosis of an anterior mediastinal mass is a guessing game at best, but a guessing game based on certain standard principles. The patient's illness began with weight loss, which is a general manifestation of disease. He had a cough, which is evidence of pressure, and hoarseness and paralysis of the left vocal cord, which suggest involvement of the left recurrent laryngeal nerve. In view of the negative bronchoscopy, I think the wheeze heard in the right side of the chest was not related to the mass but rather to emphysema. May we look at the x-ray films now? I understand that the angiocardiogram cannot be demonstrated for it is a long roll that requires four people to hold.

DR. C. C. WANG: The x-ray films of the chest taken on admission show a soft-tissue density projecting into the left-midlung field. It lies somewhat below the aortic knob and apparently above the left main bronchus. There is no unusual calcification within it. On the lateral film this density lies somewhat anteriorly and has a very sharp border. On fluoroscopy it appeared to follow the aorta and could not be separated from it. The diaphragm moved well bilaterally. The heart is not enlarged, and the aorta shows some calcification in its arch. The lung fields are clear otherwise.

DR. PITTMAN: Do you know whether the pulsation in the mass was transmitted or intrinsic?

DR. WANG: Dr. Reeves fluoroscoped the patient; perhaps he can answer that.

DR. JOHN D. REEVES: The mass did not pulsate intrinsically, but by transmission.

DR. PITTMAN: Dr. Wang, do you suspect from the angiograms that this was a vascular lesion? Was an aberrant vessel demonstrated? What was the relation of the visualized vessels to the mass?

DR. WANG: The mass appeared to displace the vessels in the left upper pole, but was not opacified by the contrast medium.

DR. PITTMAN: Is there any suggestion of peripheral shadows in either lung?

DR. WANG: No; the peripheral lung fields are clear.

DR. PITTMAN: Is the mucosa of the esophagus normal in the barium-swallow examination?

DR. WANG: Yes; there is no intrinsic involvement of the esophagus.

DR. PITTMAN: I come down to the diagnosis of an anterior mediastinal mass situated below the aortic arch confined to the left side, and transmitting pulsation. It involved the left recurrent laryngeal nerve and was probably fixed to the arch of the aorta. It was in the region of the left ductus node and may have impinged on the artery to the left upper lobe. It seems to me that given that set of circumstances, the field of discussion narrows to either a vascular lesion or a malignant neoplasm. Involvement of the nerve in benign or inflammatory lesions is so rare as hardly to warrant consideration. First about vascular lesions, one has to consider aneurysms of the aorta. An aneurysm of the transverse aorta may involve the left recurrent laryngeal nerve, but this usually gives dysphagia as well as cough. This man had no difficulty swallowing. There are rare cases of aneurysm on the concave side of the ascending aorta that may appear anteriorly and to the left of the sternum in contrast to the usual position. However, if this mass did not opacify on the angiogram, I have to say that it was not an aneurysm. Moreover, an aneurysm would not explain the marked clubbing without cyanosis.

That brings me to malignant neoplasm. The fact that this man had severe clubbing and nerve paralysis is strong evidence in favor of this diagnosis. Starting with the primary tumors, I believe the mass was not a primary bronchogenic carcinoma in spite of the history of heavy smoking. In view of the negative bronchoscopy and cytologic examination in the presence of a central lesion, there is no logical reason for making that diagnosis.

Lymphoma occurs in the mediastinum and is always a good guess when one does not know what the lesion is. Lymphoma, however, is more likely to be bilateral, although it can be localized to one side. This man had no recorded fever and no other enlarged lymph nodes so there is nothing on which one can make a reasonable diagnosis of lymphoma.

Coming to the other structures that occupy the mediastinum, I think one must consider a primary lesion in the esophagus. Although the esophagus comes in close contact with the aortic arch and left main bronchus, I do not see how I can make a diagnosis of a mass arising in the esophagus, when there is no dysphagia, no pain and an apparently intact mucosa.

Thymic tumor and teratoma both occur in the anterior mediastinum; it is always anyone's guess whether or not one of those is present.

I do not know enough about primary blood-vessel tumors to discuss them, and in the time I had I was unable to find any helpful information. So I shall leave them out.

That brings me to the metastatic neoplasms in the mediastinum. The most common sources for these are the lungs and breast. The male breast is an uncommon source, although tumors, when they occur there, are highly malignant. There was no mention of this man's breast. Since Dr. Wang said that the peripheral lung fields were clear, and the cytologic examination was negative, I do not have any grounds for making the diagnosis of a small peripheral lung tumor, such as an adenocarcinoma, which would explain the clubbing. The best conclusion that I can draw, then, is that this was a metastatic neoplasm in a lymph node from a distant focus that was not unearthed.

DR. EDWARD F. BLAND: Have you ever seen an aneurysm as slient as this?

DR. PITTMAN: No.

DR. BLAND: I wonder if someone could inform us about the difference between paralysis of the left vocal cord and fixation.

DR. WILLIAM R. WADDELL: Immediately on section of a recurrent laryngeal nerve, the cord becomes flaccid and extends to the midline. Later, as the degeneration of the nerve proceeds, the cord retracts laterally and becomes fixed in abduction. Actually, from the clinical point of view, I doubt if that helps us very much. There is considerable variation among individual cases.

DR. ROBERT E. SCULLY: Dr. Waddell, what was your pre-operative impression?

DR. WADDELL: Our pre-operative diagnosis was carcinoma of the lung. We had in mind the x-ray findings quite as firmly as Dr. Pittman. I think her points about the reasons that this mass was not a primary carcinoma of the lung are well made. The failure to visualize a tumor of central location by bronchoscopic examination is strong evidence indeed against bronchogenic carcinoma. With the pre-operative diagnosis we made, one may wonder why we felt obligated to operate on the patient. First, we had no histologic diagnosis, and when other considerations allow it, an attempt should be made to establish one. Secondly, although it is generally true that vocal cord paralysis with tumors of the lung is a sign of inoperability, in a few cases such tumors are resectable, particularly when the paralysis of the vocal cord has resulted from metastasis to a single lymph node.

CLINICAL DIAGNOSIS

Carcinoma of lung

Dr. Helen S. Pittman's Diagnosis

Metastatic carcinoma of unknown origin to mediastinal lymph nodes.

ANATOMICAL DIAGNOSIS

Arteriosclerotic aneurysm of concavity of aortic arch.

PATHOLOGICAL DISCUSSION

DR. WADDELL: When the chest was opened, the lung was found to be normal. It was immediately apparent that there was an aneurysm of the underportion of the aortic arch just below the origin of the left subclavian artery. The aneurysm was about the size and shape of a hen's egg; its wall was extremely thin and did not pulsate. There were plaques of atherosclerosis involving several areas of the aorta, particularly about the ostia of the left carotid and left subclavian arteries. The aneurysm, which was of the saccular type, had arisen in a similar plaque. The neck of the aneurysm was small, and the tissue in that region was fairly firm in contrast to the thinned-out major portion of the sac. The dissection was extended to the point where clamps could be applied across the opening of the aneurysm. As often happens, during the dissection the aneurysm was punctured. This did not cause a hemorrhage, but 10 or 15 cc. of cloudy, thin fluid escaped. The reason for this and for the fact that the angiocardiogram failed to demonstrate the aneurysm was that there was a dense clot in its opening; it lay like a cork in the opening and was easily lifted out. The clamps were applied to the mobilized aneurysm, the sac was excised, and the opening was closed without difficulty, except that the atheroma in the region made it technically difficult to place the sutures. The patient was discharged on the 10th postoperative day.

DR. SCULLY: The specimen of aneurysm wall sent to the laboratory showed severe atherosclerosis and mural thrombosis. There was complete destruction of the media, with fibrous-tissue replacement. No changes suggestive of a syphilitic etiology were seen.

DR. PITTMAN: I think it is unfortunate that we could not see the angiocardiograms because the questions I asked Dr. Wang about the relation of the mass to the visualized vessels are pertinent in retrospect.

DR. BLAND: How was the nerve at operation?

DR. WADDELL: The vagus nerve was stretched out, and there was tension not only on the recurrent laryngeal nerve, but also on the vagus nerve itself. We have discussed the possibility that the patient's ill health for two months was produced by traction on the vagus nerve.

DR. BLAND: A feature that interests me is whether or not the paralysis of the vocal cord cleared. It is too early, I suppose, to know. I have seen paralysis of the vocal cord of six months' duration with mitral stenosis that disappeared after commissurotomy.

DR. SCULLY: Dr. Wang, how often do you see a malignant tumor that is fixed to the aortic arch appeared to move with the aorta?

DR. WANG: I think that is not an uncommon finding.

Woman's Auxiliary

CONVENTION REPORT

THE 27th annual convention of the Women's Auxiliary to the Arizona Medical Association met in Yuma, April 10 through 13, 1957.

This was quite an event for Yuma. Not since 1937 has a state medical convention been held here.

The women's registration totaled 94. We were honored to have as our guest the national president of the women's auxiliary, Mrs. Robert Flanders, from Manchester, N. H.

The business sessions started Wednesday morning, April 10, with the meeting of the nurse's loan committee, and the nominating committee convening.

A board luncheon meeting followed at the Flamingo dining room, with Mrs. Oscar Thoeny, president, presiding. The school of instruction followed with Mrs. Jesse Hamer giving instruction to the incoming officers.

A civil defense film was shown at 5:30 p.m., at the Stardust by Mrs. John Kennedy, civil defense chairman.

The Blue Shield hosted the doctors and wives with a delightful cocktail party and poolside buffet Wednesday evening.

Thursday morning a general business session was held at the Flamingo dining room. All reports of the committee chairmen were heard, and election of officers was held.

A memorial service was given by Mrs. James Moore, chaplain, for Mrs. Philip Corliss, who had been active in state and local auxiliary work for many years. Mrs. Lamar Harper, also an active member of the Yuma County Medical Auxiliary, was remembered.

Coffee and rolls were available throughout the business meeting.

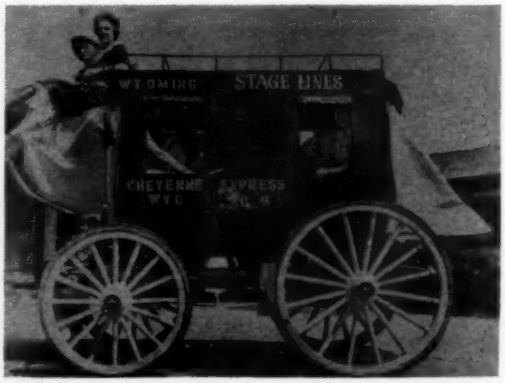
Thursday noon a luncheon was held at the Yuma Country Club. Seventy-five members and guests attended. Our honored guest, Mrs. Robert Flanders, national president, spoke on the theme of the Women's Auxiliary: "Health is our Greatest Heritage."

The tables were beautifully decorated with white wrought iron baskets of spring flowers. Each lady received a single carnation corsage. Drug companies were responsible for the other nice favors provided for our members and guests. Guests at the head table were: Dr. and Mrs. Robert Flanders, Dr. Carlos Craig, Dr. A. I. Podolsky, Dr. Charles Powell, Dr. Melvin Phillips, and Rev. Charles Crawford.

Thursday afternoon at 4:30 p.m., a style show was held around the pool at the Stardust, with fashions shown by King's and the Smart Shoppe, of Yuma. Among the many models were six of our Yuma doctors' high school daughters.

Thursday evening, following the reception and dinner hour, the Yuma County Medical Society entertained by providing an orchestra for dancing. Concluding the evening was a midnight buffet.

Friday morning was the highlight of the Womens' convention, with an All-Western Brunch. Squaw dresses were the mode of the day. Western regalia decorated the Country Club, including bales of hay. Red and white checked tablecloths were topped by Western straw hats filled with sunflowers. Vitamins



STAGECOACH DAYS — Members of the Women's Auxiliary to the Arizona Medical Association are showing their national president Mrs. Robert Flanders of Manchester N. H., how things are done in Arizona. The stagecoach transported the ladies from the Stardust Hotel to their luncheon at the Yuma Country Club in the tradiational manner of the Old West. Shown from left to right are: Mrs. Charles Powell, Yuma, new state president; Mrs. Oscar Thoeny, Phoenix, retiring president; Mrs. Dwight Murray, Napa, Calif.; Mrs. Flanders, and Mr. Fred Fairbanks, perched on top.

were had in the form of tomato juice *with* or *without*.

An old-time stage coach transported our high officials from the Stardust to the country club. Mrs. Flanders, wearing her first squaw dress, chose to ride on top with the driver.

Our state champion teenage square dance group, The Country Cousins, delighted the ladies attending with many unusual versions of Western and folk dancing.

Members of the Yuma auxiliary fashioned corsages of screw beans; these unusual beans are found on our Yuma desert. Other favors were supplied by the various drug companies.

We were honored at the brunch to have as our guest, Mrs. Dwight Murray, wife of the American Medical Association president, from Napa, Calif.

The county presidents' reports were given during the short business meeting and the new officers were installed by the national president, Mrs. Robert Flanders. Officers are as follows:

President, Mrs. Charles Powell
President-elect, Mrs. Melvin Phillips
First Vice president, Mrs. Hiram Cochran
Second Vice president, Mrs. Robert Stratton
Treasurer, Mrs. Ian Chesser
Recording secretary, Mrs. Clare Johnson
Corresponding secretary, Mrs. Ralph Irwin
Director, one year, Mrs. Oscar Thoeny
Director, one year, Mrs. John Stanley
Director, two years, Mrs. William E. Bishop

Our new state president, Mrs. Charles Powell, was presented the president's pin and gavel by Mrs. Oscar Thoeny, past president. A short inaugural address was given by Mrs. Powell. One thought she left with us: "that we must ever be cognizant of the basic aims and objectives of the auxiliary and its parent bodies, the local medical society, the state association, and the American Medical Association."

A short post-convention board meeting was held immediately following the brunch.

At 2:30 p.m., a golf tournament was held with 10 ladies participating. Mrs. Roy Hewitt won low gross, Mrs. Kent Thayer low net, and Mrs. V. A. Toland low putt.

The President's Dinner Dance was held Friday evening in the Stardust Planet Room. Highlighting the evening was the presentation of plaques to four 50-year members of the Arizona Medical Association: Dr. Meade Clyne of Tucson, Dr. Martin G. Fronske of Flagstaff, Dr. J. Newton Stratton of Safford, and Dr. Clara S. Webster of Tucson. Following were two fine talks by Dr. Dwight Murray, AMA president, and Dr. Phillip Thorek, guest speaker from Chicago.

Guest speakers' wives attending the convention were:

Mrs. Dwight Murray, Napa, Calif.
Mrs. Alber Bower, Pasadena, Calif.
Mrs. Henry Brainerd, San Francisco, Calif.
Mrs. Leon Goldman, San Francisco, Calif.
Mrs. Joseph Holmes, Denver, Colo.
Mrs. Raymond Lanier, M.D., Denver, Colo.
Mrs. Joseph Risser, Pasadena, Calif.
Mrs. Donald McNairy, Phoenix, Ariz.

We enjoyed having the convention in Yuma, and hope you will return before 1977.

MRS. JOHN F. STANLEY
Convention Chairman
Yuma

April 30, 1957

SERIOUS PENICILLIN REACTIONS INCREASING, FDA REPORTS

REPORTING on a nationwide survey of more than four years, food and drug administration physician told the Fifth Annual Symposium on Antibiotics that the number of serious reactions to penicillin has been increasing annually. Dr. Henry Welch, chief of the FDA division of antibiotics, made the report.

Since 1945, Dr. Welch said, isolated reports of penicillin reactions with a relatively high percentage of fatalities have been appearing in medical literature. The survey, covering the principal antibiotics, showed a substantially higher number of reactions to penicillin than to other antibiotics.

In the survey, 3,419 case histories of severe reactions were classified, but 424 were excluded because of insufficient data. One third of the reported reactions to all antibiotics were classified as life-threatening and about nine-tenths were attributed to penicillin.

"The trend of increase in serious reactions, especially from penicillin given by intramuscular injection," the FDA says, "shows there should be a clear-cut indication of need before the drug is administered. The study of case histories indicates that there has not been indiscriminate use of penicillin by physicians." At one point Dr. Welch points out that the number of reactions to penicillin is still small when considering that millions of persons receive it each year and that it has saved tens of thousands of lives. He said the increased incidence of reactions is to be expected in the wise use of a highly antigenic substance.

In connection with the symposium, a group of physicians and pharmacologists discussed a new product that was described as an antidote to penicillin poisoning.

"WHO" SCIENTISTS REPORT

A GROUP of WHO scientists reports that "all man-made radiation must be regarded as harmful to man from the genetic point of view," a conclusion also reached by congress' Joint Atomic Energy Committee two weeks ago.

BOOK REVIEWS

THE EYE IN GENERAL PRACTICE
by **C. R. S. Jackson,** F.R.C.S. 152 pages. Illustrated. (1957) Williams & Wilkins. $5.

The purpose of the volume is threefold: (1) To describe the common diseases of the eye; (2) to show how dangerous diseases of the eye may be recognized; and (3), uniquely, to help general practitioners to grasp the significance of reports submitted by ophthalmologists. The text is lucid and the illustrations, most of them in full color, are lifelike. It could be dedicated to all who want a synopsis of ophthalmology in relation to the body as a whole.

Stacey's Medical Books, San Francisco.

SPONTANEOUS AND HABITUAL ABORTION
by **Carl T. Javert,** M.D. 450 pages. Illustrated. (1957) Blakiston-McGraw-Hill. $11.

The author presents the observations from more than 20 years of clinical practice and research in a detailed study of 2,000 spontaneous and habitual abortion specimens, analyzed from clinical, obstetric, and pathologic viewpoints. Special attention is given to psychosomatic and phantom abortion and their therapy. There are 94 tables and 196 illustrations with an extensive bibliography.

Stacey's Medical Books, San Francisco.

MANAGEMENT OF THE PATIENT WITH HEADACHE
by **Perry S. MacNeal,** M.D., **Bernard J. Alpers,** M.D., and **William R. O'Brien,** M.D. 145 pages. (1957) Lea & Febiger. $3.50.

A well integrated triumvirate of internist, neurologist, and psychiatrist, work together on a sensible and contemporary clinical topic. The result is a readable, helpful, and inexpensive guidebook. Headaches appear under these headings: local intracranial lesions, tensions, psychogenic, vascular, and extracranial. From Philadelphia, the cradle of American medicine, this is for anybody, anywhere.

Stacey's Medical Books, San Francisco.

MARTIUS' GYNECOLOGICAL OPERATIONS
edited by **Milton L. McCall,** M.D. and **Karl A. Bolten,** M.D. 7th ed. 405 pages. Illustrated. (1957) Little, Brown. $20.

This practical manual, restricted to operating room technique, covers established gynecological procedures by description and illustrative detail. The seventh edition expands the section on the correction of sterility, abbreviates the section on urinary incontinence, omits ultraradical Brunchwig-type procedures, and presents few techniques (e.g., subtotal abdominal hysterectomy) not in line with usual current American practice.

Stacey's Medical Books, San Francisco.

BRONCHOPULMONARY DISEASES: Basic Aspects, Diagnosis and Treatment

edited by **Emil A. Naclerio**, M.D. 956 pages. Illustrated. (1957) Hoeber-Harper. $24.

Practical, complete, and up to date, 142 authorities cover the entire clinical field. Basic subjects, embryology, segmental anatomy, physiology, and pathology are also specifically considered. Questions on symptomatology, diagnosis, treatment, and prognosis are immediately answered. Emphasis is put on common problems, such as significance of hemoptysis or dyspnea, causes of cough, differential diagnosis between heart and lung insufficiency, the importance of so-called coin lesion, and how the presence of pulmonary manifestations leads to the diagnosis of a systemic disorder. Clinical and laboratory procedures which aid establishing the diagnosis are catalogued and discussed.

Stacey's Medical Books, San Francisco.

THE MENTALLY ILL CHILD

by **Steven B. Getz**, and **Elizabeth Lodge Rees**, M.D. 88 pages. Thomas. $3.50.

A brief survey of mental illness is written for parents in very simple terms to help families with children who have severe emotional disturbances better to solve their problems. Parts are good, psychiatrists might find the volume a useful tool in select cases.

Stacey's Medical Books, San Francisco.

Book REVIEWS

THE SPECIALTIES IN GENERAL PRACTICE
edited by **Russell L. Cecil, M.D.,** and **Howard F. Conn,** M.D. 2nd ed. 780 pages. Illustrated (1957) Saunders. $16.

Some specialized procedures of diagnosis and treatment, falling within the scope of the family doctor's experience and facilities, are described in detail by 15 authorities. The normal anatomy and physiology, etiology, differential diagnosis, treatment, complications, pathologic physiology, dietary regimens, therapeutic exercises, and more are given. Beautifully reproduced illustrations, 642 of them, bring home significant points.

Stacey's Medical Books, San Francisco.

PRACTICAL CLINICAL PSYCHIATRY
by **Jack R. Swalt,** M.D., **Edward A. Strecker,** M.D., and **Franklin G. Ebaugh,** M.D. 8th ed. 457 pages. (1957) Blakiston-McGraw-Hill. $8.

One of America's oldest texts, completely reorganized and rewritten, uses an up-to-date format, modern nosology, and the latest methodology. Its comprehensive coverage makes it unequivocally one of the best available standard sources of basic information.

Stacey's Medical Books, San Francisco.

FLUID AND ELECTROLYTES IN PRACTICE
by **Harry Statland,** M.D. 2nd ed. 229 pages. Illustrated. (1957) Lippincott. $6.

A masterpiece of simplicity, this cuts through the technical jargon that has long kept this subject a closed door to many. Part I sets up the principles, with an excellent opening chapter on fluid structure. Part II deals with the clinical applications. Tables and illustrations support the clear presentation. The author is an associate in medicine, University of Kansas School of Medicine.

Stacey's Medical Books, San Francisco.

THE SURGICAL MANAGEMENT OF PULMONARY TUBERCULOSIS
by **John D. Steele,** M.D. 213 pages. Illustrated. (1957) Thomas. $9.50.

This is Publication No. 1 in a John Alexander Monograph Series, to be written by thoracic surgeons who were disciples of the pioneer and by two of his close medical associates. With good indexing and complete bibliographic detail, this volume covers indications, contraindications, techniques, and results relative to surgical and medical management of pulmonary tuberculosis. It deserves the attention of both surgeons and internists.

Stacey's Medical Books, San Francisco.

THE CLINICAL ASPECTS OF ARTERIOSCLEROSIS
by **Seymour H. Rinzler,** M.D. 339 pages. Illustrated. (1957) Thomas. $8.75.

Various concepts of the etiology of arteriosclerosis are critically evaluated and are followed by discussions of diagnoses and appropriate therapies for the organs involved. The author writes from an analytical review of world literature as interpreted from extensive clinical experience.

Stacey's Medical Books, San Francisco.

PERIPHERAL CIRCULATION: In Health and Disease
by **Walter Redisch,** M.D., and **Francisco F. Tangco,** M.D., with a special section by R. L. de C. H. Saunders, M.D., and associates. 154 pages. Illustrated. (1957) Grune & Stratton. $7.75.

Peripheral vascular disease, from anatomical and physiological aspects to treatment, are concisely and adequately covered. The final chapter on the anatomical basis of the peripheral circulation is beautifully illustrated. Bibliographies are given for each chapter.

Stacey's Medical Books, San Francisco.

AN ATLAS OF THE COMMONER SKIN DISEASES
by **Henry C. G. Semon,** F.R.C.P. 5th ed. 375 pages. Illustrated. (1957) Williams & Wilkins. $20.

One hundred and fifty-three full color plates present dermatoses most frequently seen in routine practice. Abbreviated clinical descriptions, essential differential diagnoses, and outlines of treatment are included. Diseases are presented alphabetically, permitting quick reference. The author is a British physician of the Royal Northern Hospital.

Stacey's Medical Books, San Francisco.

HANDBOOK OF ORTHOPAEDIC SURGERY
by **Alfred Rives Shands,** M.D., and **Richard Beverly Raney,** M.D. 5th ed. 725 pages. Illustrated. (1957) Mosby. $9.75.

The revision is expanded and up to date, with many new sections, such as those on Fanconi's syndrome, bicipital tenosynovitis, nonosteogenic, fibroma infantile, cortical, hypertosis, and rehabilitation. The chapter on congenital dislocation of the hip is completely rewritten. The line drawings of previous editions are replaced by photographic illustrations and the bibliography is extensively revised. The author is medical director of the Alfred I. duPont Institute of the Nemours Foundation in Delaware, and his collaborator is professor of surgery, University of North Carolina.

Stacey's Medical Books, San Francisco.

PSYCHOSOMATIC MEDICINE
by **Edward Weiss,** M.D., and **O. Spurgeon English,** M.D. 3rd ed. 557 pages. (1957) Saunders. $10.50.

A standard text, gets much rewriting with new charts and tables to make a useful work just a little better. If you do not have an earlier edition, this book deserves a place on your working shelf.

Stacey's Medical Books, San Francisco.